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FISCAL YEAR 1990 BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

FEBRUARY 7 AND FEBRUARY 9, 1989

Printed for the use of the Committee on Veterans' Affairs

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FISCAL YEAR 1990 VA BUDGET

Tuesday, February 7, 1989

House of Representatives,
Committee on Veterans Affairs,
Washington, D.C.

The committee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G.V. "Sonny" Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Applegate, Evans, Penny, Staggers, Rowland of Georgia, Florio, Robinson, Stenholm, Harris, Kennedy, Patterson, Johnson, Jontz, Payne, Morrison, Sangmeister, Parker, Jones, Stump, McEwen, Rowland of Connecticut, Smith of New Hampshire, James and Stearns.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will come to order.

We are meeting today to hear testimony from the Veterans' Administration and several veterans' organizations on the priority to be given veterans' benefits and services in the next fiscal year. Prior to hearing from these witnesses, we will hear testimony from my good friend from the 2nd District, Congressman Ron Marlenee from Montana.

Tom Harvey, Acting Administrator of the Veterans' Administration, will be our first witness, and at a later time I will introduce him and his family and others who are with Tom today.

Following the statement of Tom Harvey we will hear an Independent Budget panel made up from AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars.

Due to the large number of organizations who have requested to be heard, I have scheduled a second hearing on Thursday, when we will hear from additional veterans' organizations and several medical groups.

Last week, our Subcommittee on Hospitals and Health Care received testimony on the VA facility construction plans for the coming fiscal year. We learned that the construction budget had been cut almost in half from the amount originally requested by the Chief Medical Director. It was a good hearing, and, really, we don't need to dwell on it today, in my opinion.

In preparing for the remarks this week, I mailed all Members of the committee an analysis of the administration's budget which projects a continuing decline in the quality and quantity of services to veterans. What started out as a slow trickle of veterans being turned away from VA hospitals has really become a steady stream.

It has taken far too much time than it should to process compensation, DIC, pension, education, and home loan applications. The problem seems to be the lack of staff and computer time. Really, we cannot tolerate a policy that rations services to the honorable men and women who served in defense of their country.

How did we get into this situation? First of all, the budget deficit that has existed for the past several years has caused the administration, and, to a lesser degree, the Congress, to restrict the resources for veterans. It should be stated, however, that when compared with other programs, except for defense, the space program, and the National Science Foundation, who will get an increase in the next fiscal year of $200 million, we have held our own with the Veterans' Administration.

Nonetheless, cuts have continued to come in the health care area and in the staffing of many regional offices. Year after year, the amount we have provided to fund the VA hospital system and the Department of Veterans Benefits has been less than what was needed to take care of everyone who applied. Over several years, it has taken its toll. It cannot be continued.

In addition, we established during staff investigations and hearings last year that the VA heads told us that every eligible veteran would be able to receive care. We found that they either misled the committee or they did not know what was really taking place out in the field.

But the time for finger pointing has passed. Whether it was the fault of the Administrator, the Office of Management and Budget, the Congress, or a combination of all, the time has come to recognize that something must be done.

Many of us have met with Secretary-designate Ed Derwinski in reference to the need for additional health care and GOE funds. He has listened, and I believe he will do everything he can to inform the President of the need to submit a supplemental budget to Congress.

My colleagues on the committee, I talked to Dick Darman, the new Director of OMB. I talked to him last night. I was concerned about the supplemental, what is going to happen to it—"When can we meet with you?"—and we requested a meeting with him today. He was not able to meet with us, but he assured me that no supplemental requests would be made by the President in the speech that will come on Thursday night. This will be a general budget for the next 3 or 4 years. There will not be a supplemental request in the budget message that the President delivers on Thursday. But the OMB Director told me that on February 11 or thereafter he would start looking at supplementals and he would get back in touch with us.

I bring that up to you to say that I believe when the Acting Administrator talks to us, they have submitted a supplemental budget over to OMB, and I just gave this information to my colleagues, that we will know something after February 11, and we will try to meet—Bob Stump, and I, and others—with the OMB Director.

Now, if we don't get a supplemental and additional funds for fiscal year 1990, there will be some very hard times ahead for all of us. It may be—and I want you to listen to this now—that some hospital missions will have to be changed. It may be necessary to consolidate or close some hospitals. You think about base closings; you wait until you start closing some of the veterans' hospitals, and you will really hear some racket out there, Mr. Secretary. I hope not, but we cannot continue to take across-the-board cuts in all hospitals. Otherwise, the quality of care is really going to be affected.

Let me close by saying this to my colleagues and to the administrative officials in the veterans' organizations who are gathered here. Last year, we saw legislation enacted making the VA a Cabinet-level department. We are really proud of this, and a number of you around this table or in this room today had something to do with it. But I want to emphasize that the reason it got done is that veterans wanted it done. The veterans united behind a common goal. They rallied their Members; they lobbied Members of the committees; the National Commanders came into town and met personally with Members. In short, the veterans' organizations did what it took to get the attention of the Members.

So the message I would like to close with today is for the veterans' organizations that are here this morning. If you want the Government to respond to the present funding shortfall, you cannot leave here saying, "Well, I did it all. I testified before this committee." Veterans have always had a sympathetic ear in this committee, but in the world where veterans must compete with other interest groups, the Congress has not been that sympathetic.

For instance, medicaid spending has grown by 55 percent since 1985; medicare spending has grown by 32 percent. Yes, we have done all right. Veterans' health care spending has grown only by 17 percent. Now we are falling behind. To you veterans' organizations, if you want to succeed, you must get every one of your veteran members and many who are not members to insist that when it comes time to fund priorities, veterans should be treated as number one.

So when you leave here today, go see Members of the Budget Committee; go see Members on both the Appropriations Committee of the House and the Senate; also, don't be hesitant to go and see Senate Members. You know, a lot of our problems for veterans were created over on the other side.

Bob Stump and I have scheduled a meeting with the Honorable Bob Traxler, the chairman of the Subcommittee of HUD-Independent Agencies of the Appropriations Committee, tomorrow to talk about these problems of funding.

So I am just saying to the veterans again, we can do only so much in this committee, but you have to see the other committees, you have to see the other side of the Capitol, if we are really going to be treated like we think we should be for veterans' programs.

Thank you for listening to this.

[The prepared statement of Chairman Montgomery appears on p. 103.]

The **CHAIRMAN**. The Chair now recognizes Bob Stump.

OPENING STATEMENT OF HON. BOB STUMP

Mr. **STUMP**. Thank you, Mr. Chairman.

This is my first hearing as Ranking Member of the veterans' committee, and I could not be more pleased than to be here with you as chairman. Your complete commitment to our Nation's veterans is well known and is shared by me.

Mr. Chairman, in today's hearing on the fiscal year 1990 VA budget, let's get right to the point. The VA is in nothing less than a funding crisis. We already know there isn't enough money for the current fiscal year, and it certainly appears that the proposed fiscal year 1990 budget is seriously deficient too.

It concerns me that the proposed budget calls for reductions in hospital, nursing home, and domiciliary services at a time when the need for them is growing. The proposed budget doesn't even come close to keeping with inflation, and inflation has been quite low.

We should insist that the veterans' programs remain among the highest national priorities, and, Mr. Chairman, I am well prepared to join with you in working for supplemental funding for the current year and for an adequate budget for 1990.

Veterans don't expect anything fancy, but they do have every right to expect quality health care, accurate and prompt processing of their claims for benefits, and reasonably efficient delivery of those benefits they are entitled to. With the proposed budget before us, all these are jeopardized.

With our combined efforts, Mr. Chairman, and the bipartisan support of every Member of this committee, and the help of the veterans' service organizations, I believe we can turn this situation around. America's veterans may rest assured we will give them our very best effort.

Mr. Chairman, I look forward to working with you, and I join in welcoming our witnesses this morning. I am most anxious to learn more about the fiscal year 1990 budget from them today and on Thursday.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Bob Stump appears on p. 109.]

The CHAIRMAN. Thank you, Bob Stump.

If there is no further comment from the committee, we welcome Ron Marlenee, the representative of the 2nd District of Montana, a good friend of ours.

Ron, thank you. You can sit at the witness table or sit up there; whatever way you desire.

STATEMENT OF HON. RON MARLENEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

Mr. MARLENEE. Mr. Chairman and Members of the committee, Ranking Member Bob Stump, I have never been in this committee room before, never in my life, in 12 years of Congress. I have always depended on you, Mr. Chairman, and the Ranking Member, Bob Stump, to provide the kind of leadership necessary, that you provide for the veterans of the United States of America.

I now realize, however, that you need some reinforcements, and I am here to reinforce you, sir, and the Members of this committee.

I think it is outrageous that some service-connected veterans have been turned away from necessary health care at VA hospitals.

Mr. Chairman, were you aware that veterans are receiving notices in the mail informing them that they have only a 30-day supply of medication left and then the VA wishes them God speed as the veterans try to fill their prescriptions? We, as a committee, and as the United States Congress, must bring that situation to an end.

The Big Sky Country has a population of slightly more than 800,000 people and has the third highest per capita veteran population in the United States. More than 106,000 veterans reside in the State of Montana, which means that one out of every eight people in Montana is a veteran.

In World War II, Korea, and Vietnam, Montana had one of the highest rates for volunteers. However, over the past several years, Montana has received one of the lowest health care expenditures per veteran in the United States of America, meaning one of two things—or maybe a combination of both—that either the delivery of care is highly efficient or we're getting short-changed. I think the latter may be the case because former—and, Mr. Harvey, I say this to you—former prisoners of war in eastern Montana are no longer able to receive care as outpatients. Over 700 veterans have been given a 30-day supply of medicine and turned out to seek help wherever they can find it.

The VA Medical Centers at Miles City and Helena have had to close wards and restrict inpatient care to Category A veterans and outpatient care to Priority One veterans. Both medical centers had to take these measures just to survive the next few months, and the President's proposed fiscal year 1990 budget does not offer much, if any, relief. In fact, it cuts spending on hospitals and health care by $100 million to $11.1 billion. This is a slap in the face of all veterans.

The enemies past and present of this Nation, Mr. Chairman, could not have done a better job of devastating our national commitment to the defense of this Nation. I think that is the bottom line here—the national defense of this Nation, the care of veterans is part of the cost of national defense, and we are treating it like some fourth, fifth, or sixth grade priority.

You and I both, Mr. Chairman, want fairness for the veterans. We have asked them to give a portion of their lives defending this great land. We have an obligation as a Nation to honor the promises made to veterans that we provide for their health care. I am asking you to propose stable, recurring funding that is fair for the rural veterans of Montana and the Nation.

In Montana, more than 80 percent of the veterans live over 100 miles from VA Medical Centers. The centers must have the money to pay for medications, blood, food, and supplies. These Montana facilities do not have enough money in their recurring budgets to pay for direct patient care items needed to provide the quality of care veterans expect and deserve to have.

The VA centers in Montana and the veterans themselves have gone the extra mile to efficiently manage their meager resources. I have met with people from the Veterans' Administration, and sat with these officials when they came to Montana; and tried to browbeat our administrators, telling them, even though we had the lowest cost care per delivery to the veterans, you have got to do better or you are going to have a shortfall. We, the VA, are not going to overcome that shortfall. The alternative might be shutting the doors.

The VA Medical Center at Miles City needs approximately $1.1 million to survive. The VA facility at Fort Harrison expects a $1.7 million shortfall. This may be small by big city standards, but you must remember that the hospitals in the State of Montana serve an area as large as from here to Maine, and as wide as from this area almost over to Chicago.

Over the past few years, the bean counters at the Office of Management and Budget appear to have had their own agenda—deficit reduction at the expense of our veterans.

The previous administration kept assuring Congress that there was sufficient money in the VA system to care for veterans. The hearings held by this committee last September prove that many VA medical facilities were woefully short of funds.

It is now time to stop the name-calling and finger-pointing. It is time to plug the shortfall at the VA.

I respectfully request your committee, Mr. Chairman, to approve an emergency supplemental appropriation before something tragic happens. I would also recommend the committee reject former President Reagan's budget priorities for the VA health care system and, instead, authorize $12.77 billion for veterans' medical programs, as suggested by various veteran service organizations.

Simply put, Mr. Chairman, authorizing $11.1 billion will only worsen the shortfall in funding. VA hospitals need an extra $1.6 billion—not only to close immediate shortfall but to catch up for inflation and the cannibalization of the veterans' programs that is going on all across America. That's very evident if you just stop and visit some of the VA hospitals.

Veterans have been waiting since last November for an answer to this problem. They are very anxious about what's happening to their care. I think we owe it to them to send them the signal that we as a United States Congress and you as a committee are going to do something about it.

According to American poet Robert Service, "A promise made is a debt unpaid." The American veteran has been promised that he would be cared for. We have an obligation, Mr. Chairman, and that obligation is shared by every citizen in the United States of America. It is shared by me and others.

The veteran is a logical part of the defense of this Nation. To short-change him is to short-change our commitment to the defense of the United States of America, and it would devastate the morale of those who have been our biggest boosters.

I thank you, Mr. Chairman, and the Members of the committee for your time.

The CHAIRMAN. Thank you, Ron, for that very, very strong statement. It really tracked with my own thinking. Actually, one out of eight persons in Montana are veterans. Is that what you said?

Mr. MARLENEE. Yes.

The CHAIRMAN. If you add the dependents, which are two or three per veterans, you could almost say that 35 to 40 percent of the people in Montana are affected directly by veterans' programs.

Mr. MARLENEE. Another interesting statistic along that line: in World War II when we were asking for people to volunteer for the draft. Montana was second only to one area in the United States of America. That area was the District of Columbia.

The CHAIRMAN. On volunteering?

Mr. MARLENEE. In volunteers in World War II.

The CHAIRMAN. In World War II. Volunteers who actually served.

Mr. MARLENEE. Draftees.

The CHAIRMAN. Draftees.

Mr. MARLENEE. Draftees and volunteers.

The CHAIRMAN. I tell you one way you could help us. When you see Members on the Floor such as the Chairman of the Budget Committee—Leon Panetta, talk to them. I don't want to put any pressure on him, but you can tell by the House action yesterday we are subject to pressure. Barbara Boxer is going to handle, as I understand it, the veterans' budget proposals under the Budget Committee. Bill Frenzel, on your side of the aisle, is Ranking Minority Member of the Budget, and then there is Bill Green, who is on Appropriations. It has to come from other people besides this committee.

Mr. MARLENEE. Mr. Chairman, I would be happy to do that. I would be happy to evaluate the agricultural budget in the areas that are appropriate, although we have cut back on that agricultural budget—and I serve on the Ag Committee. Although we have cut back on that budget, I would be happy to cut back further on that budget to see that the veterans receive the health care that has been promised them and that is due to them.

There are two Members of this committee, Mr. Stump and yourself as chairman, who have done more in their commitment to balancing the budget than most Members of the United States Congress. I commend you for that. I know that you recognize the problem. Thank you.

The CHAIRMAN. Any Members have any comments?

Mr. STUMP. I just wanted to thank you, Ron, for a very strong statement. Other than my own home State, I receive more mail from Montana than any other State combined.

Mr. MARLENEE. You understand why now.

The CHAIRMAN. Harley Staggers, subcommittee chairman?

Mr. STAGGERS. Mr. Chairman, Ron and I serve on the Agriculture Committee so I couldn't let him get away without at least saying hi and acknowledging that he is a very hard worker. He does his part for cutting the budget, too.

Ron, I tell you that you have Sonny to thank for the fact that we haven't cut back even further. Being on this committee during my whole term of Congress, I have seen the proposals to cut the budget every year. If it hadn't been for Sonny Montgomery you would have been here 2 or 3 years ago. Sonny has been fighting this fight for a long time, and I think that we owe him a debt of gratitude.

Hopefully, you will take his advice and go to Members of the Budget Committee and Members of the Appropriation Committee and make sure that we continue to do what we need to do for the veteran.

I also want to point out that I do know that you are very active in cutting the Federal budget, but we are at a point now that it's not just welfare queens or bloated bureaucrats, and the American public needs to recognize that. We all need to make that known to our constituents.

The Chairman. Harley, thank you for the kind words. I knew you were going to be a great subcommittee chairman.

Go ahead, Ron. You are a tough old cowboy from Montana. We need your help on this one. Will you help us?

Mr. Marlenee. You've got all the help I can give you.

The Chairman. Thank you very much.

Mr. Marlenee. Thank you and all the Members of the committee.

The Chairman. Thank you.

I believe Craig James, did you want to make a comment?

Mr. James. Yes, I do.

The Chairman. I want to say before you comment, I want to commend the new Members of this committee. The Chair has looked around and only one new Member is missing. You keep that up, you're doing all right. Thank you for being here.

Mr. James. I will have to leave at 10 and I want to apologize in advance—I have another committee hearing I have to go to, and I would like to make a brief statement.

STATEMENT OF HON. CRAIG JAMES

Mr. Chairman, Republican and Democratic colleagues, veterans: It is an honor and a privilege to be here today as we consider testimony in this proposed fiscal year 1990 Veterans' Administration budget.

I represent the Fourth Congressional District of Florida, an area that spans from Jacksonville to Daytona Beach and westward to Seminole and Lake County lines. We have a large and growing veterans' population. I sought appointment to this committee because the decisions made here impact so greatly for my constituents.

Our veterans made many sacrifices for our country, and currently we are not providing the kind of quality care that these men and women deserve. Let me say that I am greatly disappointed at the lack of proposed funding for critically needed veterans' programs in the fiscal year 1990 budget.

The American veteran population is growing older and the need for increased services is growing right along with it. It doesn't make sense to cut back services when VA hospitals and programs are understaffed. The number of veterans utilizing the VA programs is increasing tremendously.

This proposed spending plan would reduce medical facility construction, eliminate nearly 9,000 VA health care jobs, and deny medical care to thousands of deserving veterans. I fail to see the logic to make across-the-board cutbacks when the need for services is increasing so rapidly.

We have a duty to provide for our veterans. We must expand veteran services, improve the delivery system, and re-examine the entire formula about which we distribute both health care and monetary benefits.

In my district there are concerns of the planned relocation of 20 to 30 beds in the spinal cord injury unit at Gainesville VA Hospital as well as the lack of a long-term psychiatric care facility anywhere in the State of Florida.

I might add that Florida is the only one of 27 Veterans' Administration regions that does not have a long-term psychiatric care facility. A facility has long been planned but money for the construction fails to appear in the fiscal year 1990 budget.

I am also very concerned about the VA health clinic in Daytona Beach. Any adjustment to funding to Gainesville directly affects the Daytona Beach VA clinic.

I fully understand that we have major money problems. We are keeping a close eye on Federal spending but we cannot overlook the need to provide quality care and service to our Nation's 27 million veterans. We have an obligation to be there for them. They served and sacrificed for this Nation selflessly with patriotism, courage, and honor. We must not abandon them in their time of need.

I look forward to working with Secretary Derwinski, the esteemed Chairman and Ranking Minority Member of the committee, and my colleagues to act in the best interest of our Nation's veterans and their families.

Thank you.

The CHAIRMAN. Thank you. Your statement will be put in the record, also.

[The prepared statement of Congressman James appears on p. 111.]

Mr. STAGGERS. Mr. Chairman?

The CHAIRMAN. Yes, Harley.

Mr. STAGGERS. I am making a unanimous consent request, I have an opening statement, and I request that it be entered into the record, and anyone else who wants to enter a statement be granted permission.

The CHAIRMAN. Okay, that's a good suggestion.

[The prepared statement of Congressman Staggers appears on p. 113.]

The CHAIRMAN. The gentleman from Florida?

Mr. STEARNS. Thank you, Mr. Chairman. I also would like to put my opening statement in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Congressman Stearns appears on p. 115.]

The CHAIRMAN. I want to tell the new Members, also you can put your statements in the record whenever you would like, the Chair would be glad to recognize you.

If there are no more comments from our Members here we will have our second witness. Tom Harvey is the Acting Administrator of Veterans Affairs. Tom, you have some other people there with you. You can introduce them and then I will introduce some of your family members.

STATEMENT OF THOMAS E. HARVEY, ACTING ADMINISTATOR OF VETERANS AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOHN GRONVALL, M.D., CHIEF MEDICAL DIRECTOR; JOHN VOGEL, CHIEF BENEFITS DIRECTOR; ARTHUR HAMERSCHLAG, DEPUTY CHIEF MEMORIAL AFFAIRS DIRECTOR; LINDA COMBS, ACTING ASSOCIATE DEPUTY ADMINISTRATOR FOR MANAGEMENT; SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; DON IVERS, GENERAL COUNSEL, AND CONRAD HOFFMAN, HEAD OF OFFICE OF BUDGET AND FINANCE

Mr. HARVEY. Yes, Mr. Chairman, I would like to do that if I may.

My backup witnesses today are the department heads and the associate deputy administrators of the Veterans' Administration. Those will include Dr. John Gronvall, the Chief Medical Director; Mr. John Vogel, the Chief Benefits Director; Deputy Chief Memorial Affairs Director, Mr. Art Hamerschlag; Acting Associate Deputy Administrator for Management—these titles are all going to change in just a couple of weeks so it will be much easier then—Dr. Linda Combs; Ms. Susan Livingstone, the Associate Deputy Administrator for Logistics; Mr. Don Ivers, our General Counsel, and Mr. Conrad Hoffman, the head of our Office of Budget and Finance.

The CHAIRMAN. That's my staff in back, don't introduce them.

I would like to introduce Tom's family with him. His wife is Cathy Black. Cathy, why don't you stand up? She is publisher of the USA Today. Cathy, we are very glad to have you.

[Applause]

The CHAIRMAN. Tom has his parents here. His father was here last year and his mother is here today, also. John and Peg Harvey are the parents of Tom Harvey.

[Applause]

The CHAIRMAN. Okay, Mr. Administrator.

Mr. HARVEY. Thank you very much, Mr. Chairman, Members of the committee.

I very much appreciate this opportunity to appear before you this morning to provide some details concerning the fiscal year 1990 budget for the program that will very soon come to be known as the Department of Veterans Affairs.

In presenting this appropriation request and in making some brief comments about it, I think it may be useful to use just a few moments to establish a perspective for this discussion. In recent months, much has been written and said about the adequacy of funding for veterans' programs. Veterans' advocates have made heartfelt assertions that resources have not been sufficient to deliver benefits in the fashion this committee expects and which the veterans of this Nation deserve.

The VA, under the guidance of the recently departed Administrator of Veterans Affairs, conceded that funds were tight, but contended that there were sufficient resources to serve all eligible veterans.

As the committee well knows, disagreements between advocacy groups and Federal officials over adequacy of funding are common-place. But the level of intensity of this disagreement did appear to be extraordinary in the realm of veterans affairs.

It is to the credit of the committee that reacting to the obvious consternation, and more to the point, demonstrating a genuine concern for the well-being of veterans served by the VA health care system, the committee held hearings on this funding issue this past September.

The hearings brought forth a considerable amount of information, including some compelling testimony from VA field officials. And, of course, there have been additional developments since September. So before we come forward with the appropriations request for the next fiscal year, I would ask your indulgence while I give you my perspective of the programs and people which are most affected by the dollars Congress appropriates.

My intention essentially is to provide a sense of how the dollars already appropriated are being spent in delivering benefits and perhaps a sense of where future dollars should be spent, but in a way that goes beyond the extensive data already at the committee's disposal. Mr. Chairman, these budget analysis books have been provided to all the Members and to their staff and the staff of the committee for their review prior to today's presentation.

I would like to do this with a video tape which depicts day-to-day operations of the VA benefits system. At the risk of preempting the film, let me just add that it is not designed to show things through rose-colored glasses but to serve as a cinema verite' of life in the VA system—some things working with high efficiency and producing excellent results; others, quite frankly, leaving something to be desired.

Mr. Chairman, this video tape is just six minutes and seven seconds long. I ask your indulgence.

[Video presentation]

Mr. HARVEY. Why do we do all that, Mr. Chairman?

I would like to show you another brief video tape, just three minutes long, which I believe captures how we as VA employees feel, and how all Americans should feel about our Nation's veterans. The veteran in the tape, Mr. George Lorsh, was a patient at our Northport, New York VA Medical Center. He served when his country called. This veteran, Mr. Chairman, and the 27 million like him, are why we in this agency and indeed you on this committee, exist, to ensure that a grateful Nation remembers.

[Video presentation]

Mr. HARVEY. Mr. Chairman, my purpose in beginning this budget hearing with these video tapes is not to sidestep in any way the issue of adequate funding, but rather to underscore this agency's resolve in providing the best, most compassionate care we can.

My hope, Mr. Chairman, was to demonstrate the bureaucracy's and budget debates should never overlook or overshadow the quality of the people who make up this agency, and the love we in the Veterans' Administration have for the veterans we serve.

Mr. Chairman, I would like, if I may, to conclude with a personal comment. This is likely the last opportunity I will have to appear before this committee. Secretary-designate Ed Derwinski is in place and has selected our mutual friend, Tony Principi, to serve as his Deputy.

I believe the unique combination of talents they bring to their jobs portends good things for this agency, which I have been honored to serve over the past 2½ years.

Mr. Chairman, I think of you as a friend and something of a mentor. I would like to thank you for your support and the wise counsel during the time that I have been involved in the veterans' issue area. Your care and concern for America's veterans are well-known to all here. You truly have the vision to look at an aging World War II veteran and see the brave, young seaman steering his landing craft ashore at Omaha Beach, or the scared, young paratrooper preparing to jump in Normandy, knowing that he had a job to do.

Mr. Chairman, that is a vision I have witnessed, and so have many of my colleagues, as I have visited hospitals, regional offices, and national cemeteries throughout the U.S.A.

Mr. Chairman, I have enjoyed working with John Paul Hammerschmidt and Jerry Solomon, who have so ably served as Ranking Minority Members of this committee. And, Mr. Stump, I know you will provide the same leadership in that role as did your predecessors.

Mr. Chairman, finally, let me say a special thank you to your very capable staff. I have worked closely with many of them since my time as staff director of the Senate Veterans Affairs Committee. Mack Fleming has been an able counselor, and Rufus Wilson a source of inspiration for me and so many in the Veterans' Administration. I know Rufus will be retiring soon but his legend in the VA will live on.

When you think of it, it really is amazing, to have had a career that includes virtually every job within the VA, except Chief Medical Director.

Then there are their colleagues: Pat Ryan, Jill Cochran, Gloria Royce, Jim Holley, Vic Raymond, Mike Durishin, John Brizzi, Sue Forrest, and Kingston Smith. You and the committee are well served by each of them.

So, Mr. Chairman, thank you, and thank the committee for the opportunity to appear before you this morning.

I leave the VA with a heavy heart. The past few years have been among the most rewarding in my professional career. But I leave reassured that the management team coming aboard is competent and committed and that they will enjoy the benefit of your wise counsel, as have I.

Now, Mr. Chairman, my staff and I would be pleased to answer your questions with regard to the 1990 budget, and I ask that my prepared text of my remarks be placed in the record.

The CHAIRMAN. Without objection, so ordered.

[Applause]

[The prepared statement of Mr. Harvey appears on p. 116.]

The CHAIRMAN. I think the applause speaks for itself, Tom, but thank you very, very much for the service you have given as the Deputy Administrator of the Veterans' Administration. I say with all the sincerity I have it has been a pleasure working with you. You are now the Acting Administrator, and I want to wish you the best when you go into other ventures. There is a lot out there in the future for you, Tom.

Thank you for your dedication and service to the Government, and thank you for mentioning our staff. We are proud of the staff and the job that they have done for us.

To move along, what I would like to do, Bob, is stop and just ask one question, then I will start yielding to Members. We will operate under the rules as before, how you came in and seniority, going Democrat, Republican, back and forth.

Only one question, Tom, and a brief answer if you can. I understand that the Department of Medicine and Surgery request for the fiscal year 1990 budget was $11.9 billion. That is about $1.2 billion above the administration proposed amount.

Now, for new Members, the Department of Medicine and Surgery is under the VA and they do direct the hospital care and outpatient clinic care.

What about that? Is that a true statement that I made?

Mr. HARVEY. First of all, Mr. Chairman, let me also mention to you that there is a letter that perhaps has already been delivered to your office from Secretary Derwinski, which mentions—in fact, even better, it is right here. It is a letter from Secretary—designate Derwinski addressed to you and to Mr. Stump as Chairman and Ranking Minority Member, stating that he has sought from the Office of Management and Budget a fiscal year 1989 supplemental of $314 million plus 1,539 employee equivalents and an amendment to the 1990 budget of $512 million plus more than 5,000 employees in the health care account. There also are supplementals and amendments requested in general operating expenses and construction.

We have not yet received a response from Mr. Darman with regard to those, and so Secretary—designate Derwinski has requested a meeting with the President on Wednesday of this week to discuss this very matter with him.

So, yes, Mr. Chairman, the budget is less than was requested. However, we are making an effort to rectify that, and, hopefully, in the budget presented by President Bush there will be some acknowledgment of this or an amendment or supplemental shortly thereafter.

The CHAIRMAN. Wait a minute. I am a little confused. My question, the head of the Department of Medicine and Surgery did request $11.9 billion, which you reduced, which came out at about $1.2 billion less. Is that correct—before it came out of OMB?

Mr. HARVEY. Yes, Mr. Chairman, that is correct. Those were the numbers and we are attempting to get a supplemental and an amendment to correct that.

The CHAIRMAN. Dr. Gronvall did request this larger amount but the administration did cut it back?

Mr. HARVEY. Yes.

The CHAIRMAN. I see. Well, I am glad to hear that Ed Derwinski is submitting a supplemental. And, as I said earlier, that I doubt very seriously if he is going to see Dick Darman before this Thursday, based on what the OMB Director told me last night.

Mr. HARVEY. I think he is real busy right now, Mr. Chairman.

The CHAIRMAN. Yes, he is. But no supplementals, and I want to repeat again, he told me would be submitted in this budget before the Congress Thursday night. Supplementals would start as of February 11. OMB would start looking at them.

I won't take any more time, but $314 million, I don't know how you came up with that figure. You know, any amount is better than what we have got, but that is really not enough, Tom, to get the job moving.

Mr. HARVEY. The $314 million is a supplemental plus another $512 million which is an amendment to the 1990 budget. I have an idea, Mr. Chairman, we are somewhere in the ballpark of what you are expecting of us, and I am sure we could discuss it at great detail. We are striving to get those larger numbers.

Quite frankly, if we don't get them, as you said in your opening remarks, we may have to make some readjustments in the VA health care system and that could involve closing facilities, it could involve mission changes at facilities, it could involve some very, very difficult problems that we certainly recognize and certainly politically you recognize.

The CHAIRMAN. Okay. Bob Stump? Thank you.

Mr. STUMP. Thank you, Mr. Chairman. Tom, thank you for your presentation, and we wish you the very best in the future.

Mr. HARVEY. And thank you, sir.

Mr. STUMP. We heard last time that after VA appealed its OMB budget passback for 1990 that the OMB then turned around and cut another $162 million out. Is that true?

Mr. HARVEY. Let me ask Mr. Connie Hoffman to join me at the table here, Mr. Stump, to talk specifically about this. Mr. Hoffman is Director of our Office of Budget and Finance.

Mr. HOFFMAN. Mr. Stump, we did request $432 million in an appeal and the appeal was turned down. It went to the level of the Presidential Board at the White House.

Mr. STUMP. Was there anything to the rumors that if you appealed it to the President or tried again that there would be further cuts made?

Mr. HOFFMAN. Everything would have to be laid out on a table and we would start from scratch. So anything that we had negotiated prior to that would be lost and we would have to start from ground zero.

Mr. STUMP. Mr. Chairman, I hope we have a little bit better cooperation this year.

Let me ask you one other question, and then I have some questions I would like to submit for the record because of the time constraint. How much money was diverted from your equipment maintenance and repair account last year, and how much, if any, do you anticipate having to divert this year?

Mr. HARVEY. Mr. Chairman, Dr. John Gronvall, the Chief Medical Director.

Dr. GRONVALL. In 1988, Mr. Stump, we diverted some $20 million out of our equipment budget to maintain our ongoing operation. As we entered this year, we deliberately wanted to protect our equipment accounts because we had been falling behind in equipment purchases. However, we did take the step of diverting $46 million out of our activation equipment budget for projects that will need to be activated the last quarter of this year to maintain the staff level that we now have in place.

Mr. **Harvey**. May I add to that, Mr. Stump, that in the letter that was presented to the chairman, or that I have here, there is an amount of money, I believe it is $27 million, specifically requested for activation, so that we can put those facilities to work right away.

Mr. **Stump**. Doctor, what about maintenance?

Dr. **Gronvall**. I don't have that figure right before me. We should supply that for the record. We did have to divert some of the funds from that account, and I will supply that as a follow-up.

Mr. **Stump**. We would appreciate having those.

Thank you, Mr. Chairman.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

Although no dollars from the Maintenance and Repair account (M&R) were diverted by Central Office, Medical Center Directors had to utilize $30,379,065 of M&R monies for more urgent purposes in fiscal year 1988. The diversion of M&R funds reflected in the 1989 column of the 1990 budget has not yet occurred. If no additional funding beyond the 1989 appropriation is received, approximately $38.8 million will have to be diverted from M&R to personal services.

The **Chairman**. Doug Applegate, Chairman of the Subcommittee on Compensation, Pensions, and Insurance.

Doug?

Mr. **Applegate**. Thank you, Mr. Chairman. Mr. Harvey, nice to have you with us this morning.

Mr. **Harvey**. Thank you, Mr. Applegate.

Mr. **Applegate**. Best wishes to you in whatever your future endeavors.

Mr. **Harvey**. Thank you very much.

Mr. **Applegate**. Let me say that I recognize some effort has been made in the budget request to try and limit the reduction in staff which handles compensation, pension and education claims. And I am pleased also to see that you, the VA, plans to establish an Adjudication Academy. From what I am told, it seems that very little training is being accomplished in the field and this should be a very important and necessary educational tool.

However, reduction in staffing in this area of any kind is totally unacceptable. Rather, this budget should have included a recommendation that staff levels be increased by a reasonable number to allow for the DVB to improve on its current unacceptable level of timeliness in claims processing, and I think it is very, very important.

Having said that let me just throw this out to you. I am a little confused on some of these numbers that I see. There is a supplemental of some $314 million for general operating expenses, which would restore some 1,500 full-time employees, I guess. Is that correct? Am I in the ball field?

Mr. **Hoffman**. That would be in medical care.

Mr. **Applegate**. Is that only in medical care?

Mr. **Hoffman**. Yes. There is a request, however, that has gone to OMB requesting an additional $10 million for the Department of Veterans' Benefits in 1989 to sustain a level of 12,650 FTEE. In other words, they had to move monies from other than personal services to be able to support the personal services level. This would restore at least $10 million of that. And in addition, there is another $10 million being requested as an amendment to the 1990 budget to provide some additional employment in DVB.

Mr. **Applegate**. All right. Well, maybe the chairman would want to address that further.

But, given the fact that the gross decline in staffing since 1979 has directly resulted in a continued downward trend in timeliness, can you really and truthfully tell the committee that the requested further reduction of some 40 full-time employees in the level of staffing for compensation, pension and education will result in an improvement in timeliness?

Mr. **Harvey**. I certainly couldn't say that it would result in an improvement, Mr. Applegate, but I do believe that we are pursuing responsibly an effort to try to control the issue of timeliness and quality in our work product out of the Department of Veterans' Benefits. I think that as the computer operations that we are developing come on line, as we modernize the way that we do work in that very, very paperwork intensive area, I think you will see efficiency come into the system. Certainly, if not, you have been badly misled by myself and my predecessors for generations gone by, because we have invested very heavily in that.

The new Montgomery GI bill, for example, is completely being handled with optical disks; it is a paperless operation. You know, by going to that type of a system, we can eliminate a tremendous amount of rent paid for the maintenance of space just to keep the huge files we have. We can eliminate an awful lot of man-hours and personnel time and effort, just walking back and forth with the file. We have that information readily available to the operator, to the benefits counselor sitting there in St. Louis, and throughout the country. It is things like that that we are doing that I would hope would make this a much more efficient, much more effective system, and able to produce the quality of product that you expect of us.

Mr. **Applegate**. Do you have an estimate of the number of additional full-time employees that it would take to bring the timeliness of claims in process up to the minimum level?

Mr. **Harvey**. If we use the same procedures that we have right now, there is one number. What I would say is that because we are modernizing the entire operation within the Department of Veterans' Benefits we should just make the entire operation more efficient, and so, hopefully, the numbers are less than that. We ought to have efficiency increasing as staffing decreases.

Mr. **Applegate**. Okay. Well, there are some other questions I think that I would like to submit to you, Mr. Harvey, or to your successor or to Mr. Derwinski or the staff, and I will submit those in writing to you.

Mr. **Harvey**. Thank you, sir. We would be very pleased to respond to those. I can tell you that the issue of timeliness and quality in the Department of Veterans Benefits is a matter of grave concern to us. I have discussed it with Mr. Derwinski and Mr. Principi and I know that is something they are going to be focusing on as a real critical issue as they address the issues that face them.

Mr. **Applegate**. I hope so, because I think it is terribly, terribly important that we are able to reduce that time processing those claims. It is a long and very difficult hardship on these veterans to have to go and endure this long process and go without.

Mr. **HARVEY**. I think something else that will lead to that is the Adjudicators' Academy that we are setting up here in the Washington Regional Office. You know, right now people are trained to be claims adjudicators through on-the-job training. That is, of course, going to give you a certain lack of balance. There is going to be a certain difference in the way people learn to do their job and the way they, in fact, go about carrying out their job. But I think this Academy will enable us to standardize the performance of those individuals who are selected to attend that program and I think we will do better.

Mr. **APPLEGATE**. Well, I hope so. We will be overviewing that during the course of the year, and we will be having some very tough and some very pointed questions.

Mr. **HARVEY**. We will look forward to that. Thank you, sir.

Mr. **APPLEGATE**. Thank you.

The **CHAIRMAN**. Thank you, Doug.

John Rowland, Connecticut.

Mr. **ROWLAND OF CONNECTICUT**. Thank you very much, Mr. Chairman.

Mr. Harvey, I join with my colleagues in wishing you the best in the future, and thank you for your past services.

Mr. **HARVEY**. Thank you, Mr. Rowland.

Mr. **ROWLAND OF CONNECTICUT**. I would just like to touch on a few issues with regard to the so-called needs test. I believe in the budget proposal there is an indication for some legislative changes to be made to the B&C categories. I know that several years ago I was opposed to the so-called needs test because I felt, and I am sure many of my colleagues and those in the veterans' organizations felt, that there was the foot in the door and eventually slowly but surely the income levels would be changed and there would be copayments that would be increased and so forth.

And I see in the legislative proposals that under B&C categories there are various plans to increase payments for outpatient visits, prescriptions, and inpatient care. I would ask you pointblank if there are plans to deny all health benefits to B&C categories. Is that in the works, either in short-term or long-term plans of the VA?

Mr. **HARVEY**. Let me address both aspects of what you are saying. The first has to do with copayments. When I was in law school somebody said people value your legal experience based on what it cost them. One of the things that I have found since then is, if I have given free legal advice, it is treated just as so much free legal advice. I personally would very much like to see copayments for many of the things we in the Veterans' Administration do. I would like to see it for prescriptions. I would like to see it for those outpatient visits.

One of the things that is a source of frustration, and has been to many of the hospital directors that I have spoken to, is that with regularity veterans pass away and their families bring back to the VA hospital bushels of prescriptions that they have received. It seems that when they have been at the hospital they stop by, they fill up all their prescriptions because they are not sure when they are going to get back again. If it only costs 50 cents for the veteran to fill up that prescription, it would make him think: Do I need this medication? I will get what I really need. I really would like to see that because I think that people would ascribe a much greater value to the very fine services we offer if they had some contributory involvement in that.

Mr. ROWLAND OF CONNECTICUT. I think, if I can interpret from what you have said, the payment fees that have been increased or established in this legislative proposal you would interpret basically to provide, for lack of a better term, a disincentive to B&C categories to continue those services. Is that a fair statement?

Mr. HARVEY. What I would like is for people to recognize the value of the service being provided to them.

Mr. ROWLAND OF CONNECTICUT. Do you see any changes or plans to effect category A—income increases, changes in copayments?

Mr. HARVEY. I see a possible change in copayment with the provision of a copayment for 10 and 20 percent service-connected disabled veterans seeking medical care for a condition other than that 10 and 20 percent.

Mr. ROWLAND OF CONNECTICUT. One last question. Throughout the legislative proposals we see reductions in employees and combinations of different proposals and cutbacks in different categories. Has the VA analyzed where—I happen to believe that the patient load is increasing, and we still have some problems with regard to nurses and other categories of employees that we desperately need. Has the VA analyzed what impact that is going to have on health care? Where are veterans, if indeed they are being turned away, where are they going to get health care?

And if you would address the nursing situation. We have been greatly concerned with that in the committee. We have had some regional problems with getting nurses and I didn't see any specific mention of the problem in the budget. Could you make reference to either one of those two issues?

Mr. HARVEY. I would like to address them both, if I may. Let me talk about the nursing situation first. That has got to be one of the big problems facing health care in America today. The Department of Health and Human Services has estimated a shortage of some 117,000 nurses throughout the country. We are having a very difficult time competing at the salaries we can offer, even with special salary rates in areas such as your own in Connecticut, along the coasts, and in the major metropolitan areas. It is just very, very difficult for us to compete because the total pool of nurses available for all of us is a rapidly declining number. Something like one-third fewer applicants for nursing schools are applying today than did just 3 years ago. And so not only is it a declining number, but that is a problem that is going to get worse over time, rather than better.

On the other hand, we have some other places where it isn't such a problem. I talked to the Director of our hospital in Butler, Pennsylvania. He said that he has a list of people waiting in line hoping to be called to get a job as a nurse at the VA Medical Center in Butler. The salary structure of that community, the economy of that community makes that a very good, dependable, long-term job. So there are imbalances throughout the country. Throughout our system we have a very serious problem in many, many locations. We are attempting to get the additional money to pay the special salary rates that will make us more competitive where we find a shortage. But I will tell you every hospital system in America is facing that problem with us, and we are working with them, hopefully, to come up with some ways to address that.

Mr. ROWLAND OF CONNECTICUT. Any concrete plans to shift resources towards nurses from—you know, I see the reductions in the numbers of patients treated as well as employees. Any concrete plans to shift that towards nurses?

Mr. HARVEY. There is really nothing you can do to get nurses. The number of people entering that career field is in a state of very, very rapid decline. Merely increasing the salary may give a temporary advantage over others in the market in a specific community. However, a week later, the others in that market are going to increase the salary as well. I do think that a salary that recognizes the contribution of nurses, I think that recognition of the professional commitment and the professional involvement they have made to that career choice is extremely important, but we are really not dealing with a situation where you can just say I will shift resources and get more nurses over here. The number of nurses available in any given job market is absolutely tapped out.

The CHAIRMAN. Time has really—if you don't mind, John——

Mr. HARVEY. Excuse me, Mr. Chairman.

The CHAIRMAN. Is that all right?

Mr. ROWLAND OF CONNECTICUT. Yes. Would you like him just to finish the question.

The CHAIRMAN. Okay, go ahead.

Mr. HARVEY. The other question you asked had to do with where will veterans get health care. I think as we see the Veterans' Administration entering into the Cabinet; as we see us coordinating more with other health care providing entities of the Government; as Congress enacts legislation to provide catastrophic health care, which means that any American can go to a hospital for in-hospital care; as Medicare and Medicaid continue to be refined, there are going to be more options available rather than just the Veterans' Administration.

In fact, you know, we represent, with our $11 billion budget, only about 7 percent of health care expenditures in the United States. There are a lot of other places out there where veterans are already receiving care at locations of their choice.

Mr. ROWLAND OF CONNECTICUT. Thank you, Mr. Harvey. Thank you, Mr. Chairman.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Harvey, I would like to direct a few questions to Dr. Gronvall, if I could.

Mr. HARVEY. Certainly.

Mr. EVANS. Doctor, I understand, according to the Independent Budget that the veterans' organizations have submitted to us, the current level of services budget for medical care is more than $1 billion more than what is in the budget, and, again, this supplemental request we have received today is about half of that amount, and I also understand that your estimate of what is needed in a supplemental for 1989 is $635 million, and the Veterans' Administration is requesting $312 million, substantially less than even what you estimate to be needed. Can you tell us what would be left out if that lower supplemental request was granted?

Dr. GRONVALL. You are quite right, Mr. Evans. There is a difference in the figure that the Department of Medicine and Surgery estimated for the shortfall this year compared to what the Veterans' Administration requested from the Office of Management and Budget. The reason for that is that there were a number of items in our budget such as the 1-percent productivity adjustment that the Administrator believed ought not to be the subject of a special appeal to OMB and to the Congress.

I believe that the decision by the Administrator did not reflect a belief that our figure was not valid but just the desire to have the absolute minimum and totally defensible request submitted by the VA to the Office of Management and Budget.

Our current best estimate is that the 1989 shortfall from the DM&S perspective will be about $614 million. We have adjusted our operation down so that our staff is below the level that was indicated as a target in our current appropriation. If we do not receive supplemental support, we will have to further adjust the staff down as the year goes on since we must stay within the total amount of money actually available to us.

Mr. EVANS. All right. Let me ask you this. One of those programs that has not been requested—and I guess because the Administrator doesn't feel it is defensible—is homeless programs to the tune of about $23.6 million. Is that correct?

Dr. GRONVALL. In our current budget, we are continuing our homeless programs by reprogramming the funds from hospital operations. The 1990 budget also assumes that we would continue the current level of our homeless program out of internally redirected funds.

Mr. EVANS. The current level of services that we are providing, which is minuscule in terms of the amount that Congress has felt we need to provide?

Dr. GRONVALL. Correct, the current level.

Mr. EVANS. Can you be a little more specific in addition to the homeless? This 1-percent productivity cut, what else is included? What is not being included? I should say.

Dr. GRONVALL. There were a number of items that were not included in that adjustment. I already mentioned the 1-percent productivity. There was the homeless figure, which was $24 million, that you referred to; a special pay figure of $22 million.

Mr. EVANS. Who would be the beneficiaries of that special pay?

Dr. GRONVALL. Nurses and pharmacists.

Mr. EVANS. At a time that we are having this shortage in those two professions within the VA?

Dr. GRONVALL. Yes.

Mr. EVANS. The Administrator doesn't feel it is defensible?

Dr. GRONVALL. He would have to speak for himself. I am reporting the items that were not included in that request.

Mr. EVANS. All right.

Are automated data processing savings also not included?

Dr. GRONVALL. No. There were some items related to the training program for AIDS that were not included and some adjustments required as a result of the FY 1989 appropriation language. Those are the items that make up the difference between the $635 million and the $432 million.

Mr. EVANS. All right.

Now we have a problem with AIDS within the Veterans' Administration. You are telling me that the training programs for our health care professionals in the VA hospitals are not going to be increased to the tune that at least you feel they should be?

Dr. GRONVALL. As a Department of Medicine and Surgery initiative, we are expanding the training for our staff, but, again, we are having to take the funds out of our existing appropriation to do that.

Mr. EVANS. So sometimes we feel pretty good in this committee when the VA comes and says that in research we are going to spend more on AIDS, which I think is what is indicated in the Acting Administrator's testimony, but when it comes to actually implementing AIDS programs to help those professionals delivering the care in understanding AIDS and becoming equipped to deal with treating patients with AIDS, we are at least not improving the funding to deal with those programs.

If that money has to be taken out of existing resources which are inadequate generally to provide for veterans, where would that money come from? Would that be left to the discretion of a local hospital director?

Dr. GRONVALL. In essence, if we make a commitment to expand the program out of the existing budget, we earmark the funds for that budget, and then that reduces the total amount of money we have available to allocate to each hospital for their ongoing operations. So in that sense it comes out of each hospital's budget.

Mr. EVANS. Given that a 4-percent pay raise has been received by Veterans' Administration employees and the likelihood that at least a somewhat comparable increase is likely in 1990, isn't it fair to say that the costs of these two items which should exceed about $500 million will have to be absorbed by the VA?

Dr. GRONVALL. Correct.

Mr. EVANS. I am over my time, Mr. Chairman. If I could, I would like to come back. I will come back after the end, if possible. Thank you, Mr. Chairman.

The CHAIRMAN. I would appreciate that.

Bob Smith of New Hampshire, you had a victory yesterday. Congratulations.

Mr. SMITH OF NEW HAMPSHIRE. Thank you, Mr. Chairman. I know you have time constraints here with other witnesses, and I will be very brief.

One specific question and just very brief general comments. I certainly want to support the comments that were made by my colleague, Mr. Marlenee, when he spoke about his concerns for the rural veteran. I think in the 4 years—well, the second term now that I have been on the committee here, it just seems that every year at this time we are either looking at a budget that is barely maintenance or, as in the case here, apparently suggests many cutbacks. Obviously, they affect these maintenance budgets, and in some places cutbacks affect all the veterans in every Congressional district in America. But I think the VA hospital system this year, which was alluded to by Mr. Rowland, is in a severe crisis, which you have addressed in your remarks.

For example, in my district we literally cannot provide care to veterans because we don't have nurses, not because we don't have the room in the hospitals. I am not sure that is being addressed adequately.

We have a situation—this is an editorial remark—but the S&L bailout, if you will, for want of a better word, is a crisis, and I think this is also a crisis, and I don't see the same type of commitment to bail out the veteran—as we have to bail out the depositors in the S&L situation. I think we have to have the same type of commitment, and I don't see it here, and that concerns me.

Mr. HARVEY. Mr. Smith, may I just mention that it is a problem that runs across the whole health care industry, and I completely agree with you that it is a very real, serious problem.

We are doing things within the Veterans' Administration to try to deal with that. We have a nurse scholarship program. We try to encourage people to enter that career field. But it is hard.

Mr. SMITH OF NEW HAMPSHIRE. I know, and I supported that. I realize that. I think we are making some effort, but I just don't think it is enough.

One point, Mr. Chairman, that I would like to address specifically and ask you, Mr. Harvey. As you know, base closings are being proposed around the country, 80-some of those. I am sure I don't speak just for my district, but it has to be in other districts as well. In the case of New Hampshire with Pease Air Force Base, it is going to impact veterans' care, because there is a hospital there.

Assuming that hospital does not remain open—it may remain open; the Navy may take it over—but assuming in various areas around the country where base closings are going to occur and there is some service being provided to veterans, I don't see anything in the general remarks in the budget, but have you factored those situations into your budget, especially in rural areas where veterans who are provided hospital care at one of these facilities may have to travel literally hundreds of miles to get care? Are you looking at that budgetary implication and concerns specifically for those veterans who would be impacted by those types of closings?

Mr. HARVEY. I think it would be fair to say no, we haven't addressed that specifically.

Mr. SMITH OF NEW HAMPSHIRE. I would just point out that I think we need to. Obviously, we do not have the bases closed as yet, but it is pretty much a foregone conclusion. It may not impact this budget, but I would just point out that it is going to impact certainly the 1991 fiscal budget, and I would hope that you would consider that.

Mr. HARVEY. Our planning mechanism should pick that up. We have seven different medical regions across the country divided into districts, each district having sort of a balance of long-term/short-term/acute/tertiary care/various types of care, within a geographical area.

So we are not duplicating the resources unnecessarily, but we are spreading it around, taking into account the number of veterans that are residing in those areas. We have some pretty good numbers and some pretty sophisticated planning techniques that we attempt to apply to that, and then we come up against budget realities, and then we come up against OMB, and we come up against a whole lot of other places. We certainly try to take that into consideration.

I think that your comment about rural health care is a different issue than health care in Manhattan, or in Chicago, or some other places, where we have a high density of VA facilities and a high but different type of utilization and utilization rate.

Dr. Gronvall.

Dr. GRONVALL. Mr. Chairman, if I may add just a sentence or two. The information about base closings, of course, only recently became available. I have met with the surgeons general of each of the military medical services and with Dr. Mayer, the Assistant Secretary of Defense for Health Affairs. We have the list of proposed closures, including the medical implications, and our people in the VA at each of the locations where there would be a change in a military medical installation are getting the information so that we can take that into account as we make plans looking toward the 1991 budget.

It is too early to tell what the full implication would be if that package of closures all went into effect, but I wanted to assure you that we are working closely with the military medical people to be sure we understand all of those changes.

Mr. SMITH OF NEW HAMPSHIRE. One final comment. I commend you for that, because I think it is obvious that if we are looking at a shortage of facilities around the country, to literally close down facilities without any input from the VA makes no sense at all, and I would encourage you in your budgetary process to be sure to deal with those facilities where that does occur.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Bob.

Let me follow up on that. I think I wrote Dr. Gronvall or somebody down at the VA about looking into these military medical hospitals on sharing agreements that this committee implemented years ago. I think it is working well between the VA hospitals and the military hospitals sharing agreements.

Bob, will you go and tour that area, or are you just talking about losing the medical care in certain areas of base closures?

Mr. SMITH OF NEW HAMPSHIRE. In my own case at Pease Air Force Base, Mr. Chairman, it is really the loss of care where there would be a long distance for these veterans who are receiving the care there. The VA hospitals is obviously another issue.

The CHAIRMAN. Well, where we share, working between the military hospitals and the VA is working well. But the point I wanted to make here is that Dr. Gronvall should look into that situation where we are closing these bases.

Mr. SMITH OF NEW HAMPSHIRE. Yes. Obviously, veterans are receiving care at these facilities.

The CHAIRMAN. Maybe we can take over the hospital and use it as an outpatient clinic. If it was already there, that was my point.

Dr. Gronvall, you should look into this.

Dr. GRONVALL. Yes. I commented briefly that I have met with the surgeons general and with Dr. Mayer at DOD. We have the list of proposed base closings and are following up in detail to look at each one of those where there would be a medical implication, and our plan would be, through sharing agreements and collaborative planning, to take all of those into account, particularly as we are looking toward the 1991 budget.

The CHAIRMAN. We had a good meeting last week—you were there—on sharing agreement between the Air Force, which has really moved ahead, better than other services on working out a sharing agreement. Then we have two or three veterans' cemeteries that we have responsibility for on the base closures list. Is that correct, from our people here?

Mr. HARVEY. Yes, it is. The cemetery in the Presidio in California and Fort Sheridan in Chicago are on the list.

The CHAIRMAN. What happens there?

Mr. HARVEY. We will assume responsibility for those as parts of the national cemeteries system.

The CHAIRMAN. Okay. They will not be abandoned?

Mr. HARVEY. No. No, no, no.

The CHAIRMAN. Okay. Harley Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman.

May I have my last statement entered in the record?

The CHAIRMAN. Without objection.

(See p. 113.)

Mr. STAGGERS. I am concerned about the budget, and we will be having a meeting at 1 o'clock in room 334 on Thursday, for those who are interested. We will be looking at credit reform, separate accounts in the Treasury, the user fee, the maximum interest restriction, the asset loans, and foreclosed properties, if anyone is interested in coming to that meeting.

I want to move down here, because I want to make sure I can read your lips. For some people, when they look at a fee that is going to be charged to veterans, it looks like a duck and walks like a duck and quacks like a duck. When you costed out your proposal to increase the user fee from 1 percent to 3.8 percent, did you take into consideration the fact that the usage of the program would diminish substantially, or did you just use a straight line figure based on past experiences? And why would a veteran want to use your program and be charged a 3.8-percent fee for nothing? At least with a program like FHA an individual is purchasing mortgage insurance. Your proposal buys a veteran nothing. Wouldn't it be likely that reduced program participation resulting from a 280-percent increase in the user fee would produce less revenue and keeping the current 1-percent funding fee in effect?

Mr. HARVEY. Let me ask Mr. John Vogel, the Chief Benefits Director, to join me at the table, if I may, to respond to that.

Mr. VOGEL. Mr. Staggers, we did make some allowance for a drop-off in participation in the loan guaranty program. It is a very slight adjustment. We really don't know how many would drop out. In a financed 3.8-percent fee, it adds about $20 on to the monthly mortgage. How many veterans that fee drives out of the program is problematical.

Mr. STAGGERS. What is it?

Mr. VOGEL. It is problematical. I really don't know how many. We rationed it down just a little bit. We don't think we would have a large fall-off.

Mr. **Staggers**. Why would a veteran use the program? He doesn't get anything in return.

Mr. **Vogel**. The "no money down" is still the most attractive single feature. That is one of the most attractive features of that program. Other programs with conventional, of course, require money down, and some of the FHA programs require 5 percent down. This feature of no money down is the reason we think it will still guarantee about 180,000 loans with the interest rates being about where they are today.

Mr. **Staggers**. So you don't expect that you would have less revenue?

Mr. **Vogel**. We don't expect to have much less revenue, Mr. Staggers.

Mr. **Staggers**. Let me switch quickly, because five minutes is a short period of time.

Mr. **Harvey**. Not always, when you are sitting here answering the questions.

Mr. **Staggers**. You mentioned Butler, PA, I think, in response to Mr. Smith—or Mr. Rowland—when you talked about the Northeast Corridor. Butler, PA, is very similar to Martinsburg, West Virginia, and we don't have a waiting list of people. In fact, we have, I think, eight or nine nursing positions that can't be filled because of the competition in Martinsburg, West Virginia, which isn't a great urban area.

Looking at last year cuts were made. Supposedly there weren't cuts but money wasn't given to the hospital administrators and positions had to be cut. Nurses now are asked to do clerical work, they are asked to do a lot of other things, and their workload has substantially increased. So isn't part of the problem within the Administration? I mean it has nothing to do with competition.

If I have a choice to do my job as a nurse, or go to the VA and do janitorial, clerical, and all the other jobs that are being cut, isn't that part of the problem?

Mr. **Harvey**. I think part of the problem is just how one defines what is involved in the career of nursing. People go into the nursing business because they generally want to be at the bedside to provide that hands-on care.

Mr. **Staggers**. They don't go in to be a clerical worker or a janitorial service.

Mr. **Harvey**. That is right.

Now, in some ways, as we advance our computer capabilities, as we get the decentralized hospital computer program in order, there will be certain things that the nurses, or the physicians, or the pharmacists are doing directly into a computer terminal at the bedside or at the nursing station just because it is not necessary to have a separate piece of paper on which the doctor writes out prescriptions and writes out other things, and then have that entered separately by a clerical person. That is a little different than asking the nurse to do a clerical job. That is what all of these professionals will be doing. But the idea is to make it just more efficient.

Mr. **Staggers**. I can't buy into the premise that because of technology it is going to magically make these problems disappear.

Mr. **Harvey**. Oh, no, not at all.

Mr. **Staggers**. The fact is that in Martinsburg, in 1984, there were 76,000 patients approximately and 173,000 in 1988, and there are 47 fewer employees. You just can't do that.

Let me ask one last question, and I know I am running out of time, and I apologize. I know that maybe the intentions were good, but this video, this is the first time in Congress I have ever seen a presentation on the budget with what appears to be an effort at propaganda. I was very moved by it, but all of us have seen hundreds or thousands of veterans. I know the individuals that were portrayed in this video. How much did this cost, and wouldn't that be better used in some other way?

Mr. **Harvey**. There was no new footage shot for this.

Mr. **Staggers**. How much did the video cost?

Mr. **Harvey**. An absolute minimal amount. As best I can figure, the only incremental cost was the flight of two of my staff out to St. Louis where——

Mr. **Staggers**. It cost something to do that video, and it cost something to give that nurse in Martinsburg, West Virginia, additional pay, or hire a clerk worker, and it seems to me that it cost a minimum of $20,000.

Mr. **Harvey**. Not at all, absolutely not at all. If it cost $1,500, I would be surprised.

Mr. **Staggers**. Thank you, Mr. Chairman.

Mr. **Harvey**. The video was prepared from stock footage that we had in store at the Learning Resources Center in St. Louis. We have a very highly competent staff there. The extra work they had to put into this was work that they were going to be doing anyhow and doing the type of things that they do. Two men, Dennis Box and Al Mann, flew out there to work with them on preparing the script for it, but that really was the only incremental additional cost.

The second video, the "Look At Me" video, is part of a training program we have for new VA employees. This was abbreviated from that. But the idea is, to try to convey to the new employees, who are young, who possibly weren't even around when the Second World War was being fought, that this is who our patients are, there is something more to them than the crabby old man you are dealing with day to day; this is a person who served his country; this is a person who had a family, who is a father, who is a grandfather, who was once young and vigorous and, indeed, passed the physical and the mental tests to get into the United States military. That is a message that is very important for us to convey, and that is an important part of our training program.

Mr. **Staggers**. I don't think it is an important message to portray to the individual members of this committee, because each one of us knows, or at least it appears in my mind, that this administration is the one that comes and makes the proposals to cut that budget.

Mr. **Evans** [presiding]. The gentleman from Georgia.

Dr. **Rowland of Georgia**. Thank you, Mr. Chairman, and may I apologize for being in and out this morning—that recurring problem of having another meeting at the same time. So if I go over some ground that has already been plowed, I apologize for that too.

I just want to commend you, Tom, for all that you have done and wish you well.

Mr. **Harvey**. Thank you, Dr. Rowland.

Dr. **Rowland of Georgia**. I think you have done a difficult job to deal with the budget constraints that we are operating under now.

I want to make two or three comments expressing the distress that I have over the continuing horizontal cuts that we have seen recently and the constant struggle to maintain quality of care which, in my opinion, has been maintained principally because of the dedication of the people in the Veterans' Administration health care facilities, which has a new name now, I understand, the Veterans' Health Service and Research Administration rather than the Department of DM&S.

But it seems to me that if we don't maintain care for the veterans that we have been doing in the past, we will begin to see those veterans not coming to the VA but actually going to medicare and/or medicaid for their care. There will certainly be no savings to the Government if that does happen. But I think it will certainly cause a deterioration in the Veterans' Administration health care delivery system.

It seems to me that we ought to be able to, here in Government, get together and address the problems that we have, and I think that we can do that. If I understand the budget process correctly, there will be a budget resolution that will be adopted, and the authorization of this committee will have to conform with that budget resolution, and then there is the appropriations process where the money that we have authorized for various programs and areas is appropriated.

But the Office of Management and Budget has seemed to be a thorn in our side over the past 3 or 4 years anyway. The chairman has talked with the new Director of that office and also with the now-Secretary of the Veterans' Administration, and I hope that we will all be able to work together to maintain the amount of funding that is needed to provide adequate care in our system.

I believe that if people can get together and work together, they can accomplish things, rather than being confrontational all the time, and we've certainly been confrontational with OMB recently. But, if OMB continues to be confrontational with us, then it seems to me that we in the Congress on this side or the other side of the Capitol can authorize and appropriate the money that is necessary to run the Veterans' Administration the way that it should be operated, and that is what I hope we will do.

If it becomes necessary to fight with OMB even more than we have, then I think we need to be prepared to do that. But I would like to see us all work together to achieve that aim. I think that is one thing that we can do here in the Congress, is work better—the House and the Senate—to achieve that goal, and I would hope that is what we can do.

I think there are other things that can be done, too. I made a visit to hospitals the latter part of last year in the eastern part of the United States, five hospitals, and I heard without exception that directors want more flexibility in transferring funds from one account to another, which they cannot do now. I think that is one way to continue to provide quality of care.

I have seen things constructed and renovations take place in the veterans' hospitals that were totally unnecessary and it was only done because they didn't want to lose the money that it had. I think that is an area that we can look into, and we need to look into and make some changes.

I think there are a lot of things that we can do. So, having said all of that, I just will look forward to working with Members on this side and Members in the other body, and hope that we can work with OMB to achieve these goals and that we will not have to continue to see horizontal cuts made, and not even vertical cuts. I am really concerned, if we start making vertical cuts and closing of facilities, that we will be going to see the beginning of the eventual deterioration and destruction of our medical care delivery systems in the Veterans' Administration, and I sure don't want to see that happen, because there is so much good that we do.

I see my time is up, but let me ask a question, and I guess I want to ask this question of Dr. Gronvall. The chairman covered earlier the reductions in the budget for VHS and RA that was submitted to the Administrator. The Administrator didn't make any significant cut in that. They kept it pretty well as it was. But in going down the sequence of events and looking at them, when we get down to the OMB approval allowance, which was almost $11 billion, $10.9 billion, and then the Presidential Review Board reduced that by $160 million. And I have heard rumors about why that happened, but I would like to hear, Dr. Gronvall, why was that reduction brought about and that level?

Dr. GRONVALL. All I can testify to is the fact that we did appeal, made a presentation about our needs, and then we were subsequently informed in writing that our appeal had been turned down and that the final level that would be included in the President's budget was $10,741,000,431.

Dr. ROWLAND OF GEORGIA. But you were reduced $160 million. Not only was your appeal not—you weren't sustained at the same level, you were reduced about $160 million further; is that correct?

Dr. GRONVALL. Yes, sir.

Dr. ROWLAND OF GEORGIA. Why did that happen?

Dr. GRONVALL. I cannot speak to the reason. A Presidential Review Board had been created. We met with that Board. The Administrator and I made our presentation, and we were subsequently informed in writing what the final decision was and no reason was given.

Dr. ROWLAND OF GEORGIA. You did not give a written explanation as to why it was done then?

Dr. GRONVALL. We had a written decision but not an explanation.

Dr. ROWLAND OF GEORGIA. Not an explanation. So you wouldn't be able to venture as to why that took place. You didn't hear any reason given for why that was reduced by $160 million.

Dr. GRONVALL. No. When we were at the Board presenting our needs we were questioned about our needs, but there was no discussion of a reduction of the budget below the level that had within the past few days been approved by the Office of Management and Budget.

Dr. **Rowland of Georgia**. Well, of course, you can hear anything, and what I heard was certainly not pleasing to my ear, and it was a rumor. I want to say that it was a rumor as to why that $160 million was deleted, and I am going to state what the rumor was. The rumor was that they didn't want to be bothered. They were kind of aggravated about the appeal. That is what I heard. I don't know if that is true or not. I certainly hope that that is not true. And, if there is anybody here from OMB, I would like to know from them whether or not, or what the explanation is for that reduction.

Mr. Chairman, I apologize for the amount of time that I have taken here.

Mr. **Evans**. I thank the gentleman from Georgia for his questions.

The gentleman from Massachusetts is now recognized.

Mr. **Kennedy**. Thank you very much, Mr. Chairman.

Welcome, Mr. Harvey, and Dr. Gronvall, and everybody from the VA.

The questions I have really pertain to the overall budget levels of this year's funding, and, obviously, we have had some rubs over the course of the last couple of years about whether or not the figures that you are representing here are figures that represent the real need of the veterans or whether or not they represent the needs of the budget-cutters in OMB, and I know that both of you have spent your lives trying to represent the needs of veterans and so I would like to center around that aspect of the problem.

As I understand it, the VA medical budget this year calls for a reduction of about 17,516 in the number of patients treated in VA hospitals, when we know that service-connected veterans are already being denied access to patient services. The same budget calls for a decrease of 14,252 patients treated in long-term care facilities, when we can document that chronically ill veterans are taking up acute care beds because there is no longer long-term beds available. The same budget also calls for a decrease of 2,400,000 outpatient visits and at the same time when hospital administrators are being urged to shift to outpatient care in an attempt to save inpatient dollars.

Now we could build a question around that, but some other statistics would indicate that you have cut the number of FTEE levels of hirings this year by 191,287, which is 3,000 FTEE levels lower than the mandated levels in the appropriations budget. Now you have come in, I assume, in an attempt to respond to all of that with a request for $314 million of supplementals. However, when I just sort of add up these figures you come up with about $211 million. If you look at homeless contract hospitalization, higher special pay costs, productivity initiatives, and ADP savings, that comes up to about $211 million. And so the difference between that and the 312—maybe that is 212, rather, so there is about a hundred million dollars difference, and that hundred million dollar difference is supposed to pay for, and the last stat that I will throw at you, is that you have come in with a budget that reflects a very small inflation rate, lower than what the CBO itself calls for, and obviously that is general inflation having nothing to do with hospital inflation, which it seems to me this budget is much more tied to.

So it just would appear that the evidence would demonstrate that the budget that is coming in is an OMB budget rather than a Veterans' budget, and I wonder if you can just respond to that given the facts that we have been through.

Mr. HARVEY. Let me just talk about process generally. Internally, within the Veterans' Administration, Dr. Gronvall presented his budget request, various decisions were made internally, various things were or were not funded. We then went to OMB, I can't tell you the exact number we requested from OMB. They made various adjustments downward from that.

I think probably Dr. Rowland hit a very interesting point, which is that when you do that you don't save anything. If somebody doesn't come to the VA for health care but instead uses Medicare or Medicaid or catastrophic health insurance, you wind up with the Federal Government having to pay a net even amount. I think it will be a good thing with Mr. Derwinski in office, with Mr. Derwinski apparently really taking on some of those issues more aggressively with the Director of OMB and with the President. He has asked for a meeting with the President tomorrow to talk about the need for additional funding for these programs.

Dr. Gronvall and I would probably, you know, disagree within some sort of a range of what number we really do need. You know, should a 1-percent productivity cut go into effect. I believe the Bureau of Labor Statistics' numbers for 1987 said that in the health care industry there was a 3-percent productivity improvement in that industry. No one wants to commit to that up front, but, in fact, restrospectively that happened.

Mr. EVANS. Would the gentleman yield?

Mr. KENNEDY. It does seem that the dilemma that we continuously seem to face in this committee is that the only way that we are able to get a handle on the specific needs of the veterans is by talking to the VA or talking to the veterans' groups, and the difficulty is that, I think when every single Congressman that goes back home to their districts, we hear strong complaints about how veterans are being treated. We come to you and you are reflecting to us an OMB budget, not what the veterans' needs are. And we have got to escalate this to a point where we are getting down to what the veterans' needs are.

Yes, Lane.

Mr. EVANS. I thank the gentleman for yielding. If we are going to have a 1-percent productivity cut, what are the numbers of elderly World War II veterans that are going to be needing medical care from the Veterans' Administration? What percentage increase of patients would we have in that category alone that would offset that 1-percent cut?

Mr. HARVEY. There obviously is a group of people who will be coming in who will be needing additional care. There are various things we are doing to try to keep them from having to utilize inpatient hospital care. For example, the hospital-based home care system is something that is strongly recommended by the Veterans' budget.

Mr. EVANS. My question is directed at this. To say that we are only cutting the VA by 1 percent when productivity within the medical sector generally has gone up by 3 percent obscures the fact that the numbers of patients coming into the VA are increasing each year, and, in fact, particularly among that elderly World War II veteran population requiring more and more intensive health care from the Veterans' Administration.

So, you know, maybe it is that we can make the Veterans' Administration as effective as possible. I don't think any Member of this committee is against that. But simply cutting the budget 1 percent is not going to help us deal with the increasing numbers of people coming in. The savings we might have with increased productivity are going to be offset by the increased numbers of people coming in.

Mr. **HARVEY**. And, indeed, one of the things I would hope to do as we look at various areas where there could be additional savings in our system is again much along the lines of what Dr. Rowland said. Not cutting just for the sake of cutting, but cutting so that we can divert resources to where there really is a greater demand for those resources.

Mr. **KENNEDY**. But, you know, I think just to reclaim my time for one—not that I have a lot of time left, Mr. Chairman. But the fact is that what we have got to get to is certainly it is important to balance the Federal budget, and the people of our country have a right to know where their taxes are being spent. But, if we have made a commitment to the Nation's veterans that say if they have been hurt, if they get sick, that our country makes a commitment to taking care of them, then that commitment is higher than any single individual's willingness to go out and get themselves elected on a no-new-taxes pledge.

And I would just think that rather than wedding ourselves to some no-new-taxes pledge, if we have got veterans that are being denied access to health care facilities in our country, that we ought to be raising hell about it and the VA itself ought to be raising hell about it, not sitting there trying to please some accountant over at OMB.

I can't believe how we have put the cart before the horse on this one. Anyway, my time is up. Thank you.

[The prepared statement of Hon. Joe Kennedy appears at p. 123.]

The **CHAIRMAN**. The time is up. To follow up, it seems like you penalize if you do good productivity. That you penalize them by 1 percent by working hard and doing things in the hospital. You penalize them and take the funding away from them. I really never have liked that 1-percent productivity.

Mr. **HARVEY**. Mr. Chairman, I can assure you there is no hospital director out there who looks forward to it either. But some of this really is the way health care is delivered. My mom had an operation for cataracts a few years ago. It was done on an outpatient basis. That is the way cataract surgery is done today. People don't spend as much time in the hospital because of new technology and new techniques. We are able to do things better and faster and do many things on an outpatient basis which only a relatively few years ago would have been a much more costly inpatient procedure.

The **CHAIRMAN**. Right. But we need the equipment to do that, though.

Mr. HARVEY. Well, we need the equipment and, you are right, we need the incentives. I was talking to a physician, the Chief of Cardiology at West Roxbury Medical Center, also the Chief of Cardiac Surgery at Harvard, the affiliated medical school, and he said, you know, there are various patients coming to him for cardiac surgical procedures at the VA who are Category C patients and they are only paying that minimal amount of the Medicare deductible. These are people who are employed. They have employee-supported insurance. He said, "Why is it that we can't go after that insurance to help fund the programs that we are doing here?" There are things like that that I think we really could do to help us out.

The CHAIRMAN. Liz, before the Chair yields to you, let me ask one more, a comment or question that came on Lane Evans' or Joe Kennedy's. I have been getting the impression that treatment of veteran patients in our hospitals, that private versus veterans, that we could treat those patients, including Medicare, a hundred dollars a day less than what it would cost Medicare to put them in a private hospital or if these patients went to private hospitals. Can you back up your statement? It is the same cost, I think you said, on Medicare versus veterans' hospital care per day.

Mr. HARVEY. The one place where I would probably disagree with you, Mr. Chairman, is health care in a teaching environment, because there is a separate component that goes into the education of the residents, interns and others who are in the affiliated medical institutions, is more expensive because of that educational component.

What I would say is, certainly, if you parse out that educational component, the cost would be highly competitive, and I think of comparable quality.

The CHAIRMAN. Well, I think we need to get into this further and really just see the cost. Because I have been saying for several years now that we can treat these patients much cheaper than you can in private hospitals, and I can't see why we can't. We got our own hospitals. We got our staffs that have been on the job longer. We don't have bond issues we have to pay off, interest rates to pay. And we have per patient, don't we, Dr. Gronvall, professional people per patient, we have less than they have in private hospital staffs?

Dr. GRONVALL. Yes. All of the studies that have been done, I think, conclude that the cost of providing hospital care in the VA is either the same or less than the cost of providing the care through Medicare or through private hospitals. So I agree with you that the cost through the VA is less.

The CHAIRMAN. Dr. Rowland?

Dr. ROWLAND OF GEORGIA. I want to ask about the teaching.

The CHAIRMAN. Can I get Liz Patterson? She has to leave. Then I will come back.

Mrs. PATTERSON. That is okay.

The CHAIRMAN. All right. Okay, go ahead.

Dr. ROWLAND OF GEORGIA. Thank you. I am sorry to use up so much time.

But you mentioned about the teaching and there may be a difference there. Under Medicare hospitals do get money for teaching, or for education for their residency programs. But isn't it true that in the Veterans' Administration we also have money for these residency programs?

Mr. HARVEY. I know we have a budget of something in excess of $200 million, I believe, for stipends for residents and in excess of $200 million for other associated teaching costs.

John, is that correct?

Dr. GRONVALL. Yes, correct.

Dr. ROWLAND OF GEORGIA. Well, the reason I asked the question, Ed, do they balance out or is there a considerable disparity in the amount that comes to hospitals through the Medicare program vis-a-vis what we have in residency programs in the Veterans' Administration?

There are some proposals on the table now to significantly reduce the education payments through Medicare. I believe if you looked at a comparison of some past years the amount provided for educational expenses through Medicare has been more generous than the amount we can provide to the VA hospitals through our own appropriation.

Dr. ROWLAND OF GEORGIA. Isn't it not true that OMB has already suggested a proposed 300 cut in the number of residency programs in the VA?

Dr. GRONVALL. The 1990 budget proposes a reduction in the number of house staff. That grows out of the constraint of the total amount of money available, or approved by OMB for the 1990 budget.

Dr. ROWLAND OF GEORGIA. It goes back to the same old thing of we are getting cut and it is going somewhere else. I see you are shaking your head in agreement.

Dr. GRONVALL. I don't know where it went. I can confirm that we got cut.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

The CHAIRMAN. For the record, I would like to submit just one page that we got from the DOD that makes my point. On bone scans conducted in civilian non-Federal facilities, the cost per procedure is $407, and the cost per procedure in a VA facility is $76. The total cost savings through sharing agreements, was $53,000. We did it $331 cheaper, Tom, than the civilian hospitals, so we are bound to be saving some money here. And this is from DOD, not from VA.

(See p. 127.)

Mr. HARVEY. I think that is absolutely true, Mr. Chairman. I think those sharing agreements are dynamite. I think Mr. Evans is the one who said that, you know, we are not trying to retire a bond indebtedness, we are not trying to recoup various other costs like that, and therefore where we get together and provide these services we can do it in a really mutually beneficial way.

The CHAIRMAN. And one other comment: We do collect from Category B on their health insurance if they have it, or hospitalization insurance. I want to state that for the record. That we are collecting the money.

How much have you collected?

Mr. HARVEY. Regrettably, not nearly as much as we would like.

Dr. GRONVALL. In 1988, we collected about $105 million from insurance held by veterans.

Mr. **Harvey**. Although we billed $220 million, didn't we? So there is a substantial disparity between the amount we billed and the amount we actually collected. We are working to rectify that situation.

The **Chairman**. Liz, at last.

Mrs. **Patterson**. Thanks, Mr. Chairman. I also want to thank Mr. Harvey for his years of service.

I have sat here patiently and I have missed a meeting I am supposed to be attending in the Banking Committee dealing with leveraged buy-outs. I thought it was more important for me to be here today to make certain that our veterans aren't sold out, so I have been sitting here listening faithfully.

Last year, and my first year here, my major concern was the lack of nurses and the availability of nurses. We put into our budget last year—it was one of my suggestions. It was to make day care available where possible at Veterans' Administration facilities. My question to you would be, have we encouraged Veterans' Administration facilities to put these day care facilities in operation to encourage nurses and other staff to not worry about child care? That would be my number one question.

The second question, also relating to nurses, is how much are we really doing with the nursing shortage? As we talk to colleges and universities—I know we have the scholarship program, but as we encourage people to go into nursing and to stay into nursing—not just females, males and females—and when we take away some of the arduous paperwork that one my colleagues mentioned and really let a nurse when they go into nursing be a nurse.

Mr. **Harvey**. Mrs. Patterson, may I respond in some considerable detail to your question about child care? Because I have in this material quite a lengthy set of information about that. But let me just in summary tell you we have not yet implemented it, we are proceeding to implement it. There is some bureaucratic resistance at some elements of the Veterans' Administration to do that, partly having to do with allocating who it is that has to pay to remodel a facility to be an appropriate child care facility in a health care institution as opposed to just another hospital room.

But we are pursing that and I can tell you my lovely wife, who is sitting behind me, leans on me with some regularity about why don't we do more about that because that just is one of the key issues that so many, principally women, feel constrains them in their ability to work outside the home. I think it is very important and I think it is one of a package of goods that we need to look to offering to potential employees, and in this case principally women. The nursing career field is 90 to 96 percent women.

We are pursuing that, and I will during my remaining time at the Veterans' Administration keep leaning on people to do it. I think it is very important. It is just one of those important things that makes this an attractive place to work.

You asked about how do we get people away from doing the paperwork, get them to doing the hands-on nursing care that they got into the nursing career field to do. We have a couple of different groups within the Veterans' Administration that are working trying to address the career field of nursing, trying to determine how do we make it more attractive, what are the disincentives for someone to go into that field of work, what would draw them somewhere else, and is there a way for us to shift the balance of that?

A gentleman who until recently was the director of our hospital in New Orleans, Mr. Greg Haig, has just recently become the director of an office exclusively oriented towards the recruitment and retention of professionals in areas such as nursing that are hard to fill. Hopefully, we will be able to do that. But it is going to be a continuing problem for us because of the shortage of nurses and the decline in the number of nursing schools and the decline in enrollments in nursing schools throughout the country.

I was talking to a colleague, the executive director of one of the major veterans' organizations, recently, who said, "Why don't you just tell the various hospitals where you have an affiliation with a medical school that you won't continue your affiliation with them unless they also maintain a nursing school? Because you have plenty of doctors. We are looking to a surplus of doctors in America, but this shortage of nurses is continuing to decline." That is pretty hard-headed, and certainly the gentleman I am talking to is a pretty hard-headed guy, but I admire his thoughts on how we might try to address that problem.

It is probably the biggest health care issue facing American health care, next to the aging of America and AIDS. What do we do about a shortage of nurses throughout society?

Mrs. PATTERSON. My comment might sort of go along with my colleague's, Mr. Staggers, earlier. Maybe we should be spending more of our time producing videos to be used on commercial TV to tell young men and women that it is a good profession to go in, that there are benefits, and that we are not cutting the budget that relates to nursing care. I think that is where we need to spend our time, really recruiting, and doing it on public TV or wherever.

Mr. HARVEY. Actually, we have a very fine video that we have used exactly for that purpose. We have some very high quality video production facilities—the St. Louis Learning Resource Center or the Northport VA Medical Center's Learning Resource Center, which did the second video today—to do just that. We have it as a public service announcement. We used it during National Nurses' Week, trying to get as much exposure as we could on public TV to show people that this can be a very rewarding career.

I could send a copy of that video up to you and you or your staff could take a look at that. It is something that we are very proud of. It was professionally done with professional actresses; it is a high-quality product.

The CHAIRMAN. Claude Harris.

Mr. HARRIS. Thank you, Mr. Chairman.

Mr. Harvey, I, too, want to wish you well in whatever endeavors you——

Mr. HARVEY. It sounds like you and a lot of your colleagues are happy to see me moving on.

[Laughter.]

Mr. HARVEY. Thank you very much, Mr. Harris, I appreciate that. I recall the day we were together at the dedication of the Fort Mitchell National Cemetery.

Mr. HARRIS. And that was a great day.

One of my colleagues talked about the video. I thought it was a good video, and I know that most of us have been to the veterans' hospitals in their area, and if they haven't, I certainly would suggest that they go because it is a constant reminder of the problems that we are facing. I know it has been a tough job for you and Dr. Gronvall and the other folks that work at the Department, and I think it might be a good idea, in talking about and showing the video to remind people of our purpose, that, if possible, you might show it to OMB.

Mr. **Harvey**. You know, I will tell you the truth. Yesterday, when Mr. Hoffman and I were discussing the presentation today, he said, "You know I wish we would have had that and used it to begin our budget hearings with OMB." I have found in my very limited experience in budget hearings with OMB that it is a frustrating experience. Because you wind up dealing so much at the minutiae level that you don't get a chance to say why are we in this business, what are we doing here, and that I think is the key question that we need to look at.

Mr. **Harris**. I agree with you, and I think that we may get a different result sometimes if some of the people that make those decisions had a firsthand experience with the problem.

But we know that the veteran population has already tightened its belt because we have seen all sorts of means testing and other things already. And I know that if you talk to the veterans they are just as willing as the next person to help us get out of the economic hole that we are in, but certainly they don't feel that disproportionate cuts—and I think that is what we have had in the last few years—in their budget is really fair to them.

Certainly one of the reasons that I asked to get on this committee, aside from the fact of serving with General Montgomery, is the fact that I want to be a part of helping this country keep its promise to its veterans. That is certainly something that I want to work on along with other Members of the committee, because I know we are all interested in the same thing, and the reason among others that I felt like we needed this head of the agency to be a Cabinet-level position was to have a person at the head table when these matters are discussed. It is certainly not enough to add a chair at the head table if we are going to move beds out of the bedroom.

So call on us anytime if we can be of service to you.

Mr. **Harvey**. Mr. Harris, I can tell you that I have been very impressed by Secretary-designate Derwinski, who really does hear what you and Chairman Montgomery are saying. He has sat in with the caucus on this committee and has taken action, I believe, very early on, even prior to his confirmation—which as everybody in this town knows is sometimes a little hazardous—to go up against OMB and to ask for this meeting with the President, to put these very considerations right there on the table.

So I think he will be an effective spokesperson, and I think the veterans have the sort of an advocate and a representative that they would hope to have when they sought this elevation to Cabinet status.

Mr. **Harris**. Well, we certainly need a guy to be the quarterback, not an opposing tackler. You know, football is important down our way.

We have some meetings coming up with some of the Members of the Department, that we've got some ways at the University of Alabama, trying to help the Veterans' Administration with some problems. I mentioned one the other day—you weren't here—about saving on heating and air-conditioning costs with some new thermal energy projects. Certainly any time we can save dollars, we need to do that. In Birmingham we have a world class facility.

Mr. HARVEY. That certainly is true.

Mr. HARRIS. With a walkway built across into the Veterans Hospital. It offers veterans access to that same quality of care. We certainly have a program that we're working on, and that Dr. Gronvall is aware of. We hope it gets included in the action.

Thank you, Mr. Chairman.

[The prepared statement Hon. Claude Harris appears at p. 128.]

The CHAIRMAN. Thank you very much, Claude. Thanks for your patience.

We have Tim Penny and then Charlie Stenholm, and then we'll have our next panel up. I would hope we could finish before we get our first vote around 12 o'clock.

Tim Penny.

Mr. PENNY. Thank you, Mr. Chairman.

First of all, I want to express my appreciation to the new Secretary for sharing with this committee the letter he has sent to the President and the Director of OMB. I don't recall in the last several years the Administrator of the Veterans' Administration ever sharing with Congress the request that had been made to OMB.

Mr. HARVEY. I can't imagine that OMB is going to be very excited about hearing you've got a copy of the letter.

Mr. PENNY. I think it's a good development, and I want to stress this morning that it's the way this place ought to operate. If the VA advocates one kind of a budget and OMB or the White House, involving individuals who know far less about veterans' needs, recommend a different budget, you shouldn't have to be subjected to a code of silence. You ought to be able to come and share with us what you feel those needs are and let us fight it out with the administration if we differ over the numbers.

We've been in a difficult situation when we can't get the information we need from the folks who ought to know, and when we have to go out, as we did last summer, and do research on our own in order to identify those needs. So I hope this is a sign of the way this administration intends to function, to allow their Cabinet members to be honest with the Congress and to share with us some of the internal disputes that we know must occur within an administration. In the final analysis, you've got to be team players, but you can tell us what you advocated and there's nothing wrong with that.

Beyond that—I know I risk getting into a sensitive issue—but it's very likely, almost certain, that we're going to reject the pay raise today. You might tell Secretary-designate Derwinski that, in his discussions with Mr. Bush, he might indicate that the amount of money saved by not giving judicial, administrative and Congressional individuals a pay raise is about what you're going to need to cover the requests that you've made for fiscal year 1989 and fiscal year 1990. While I think it's the right thing to do to reject the pay raise, I would be doubly pleased if it had the effect of giving us some of the money we need to take care of these veterans health care concerns.

I want to ask you just two questions. One, what kind of projections do you have on outyear funding needs for health care, the medical services—and Dr. Gronvall may want to answer this. I know we've got declining numbers of overall veterans, but increasing numbers of those who are elderly. Where do you project the current service level to rise to over the next 3 or 4 years to accommodate that health care population?

Dr. GRONVALL. Mr. Penny, let me answer that in a general way. We have tried to project the future. You're quite right, that the absolute total number of veterans is declining. But as the veterans population, particularly World War II and the Korea era, ages, the utilization, demand and need for health care services increases. That applies really both to acute hospital care as well as to long-term care. So we have projected and predicted the increasing demand, which extends out at least until the year 2000, and probably significantly beyond that, before the total demand for VA health care services would begin to decline.

Mr. PENNY. Let's say this coming fiscal year 1990 your funding level turns out to be $11.2 billion for the hospital and health care needs. Give me a rough idea of what percentage increase you would anticipate being necessary for 1, 2 and 3 years beyond that, just to maintain current services and to handle the demographics?

Dr. GRONVALL. Well, that figure that you're talking about is not a current service projection.

The budget that the Veterans' Administration's Administrator went to OMB with was $11.860 billion. That was the starting point.

Mr. PENNY. I apologize. I had the number wrong. I mean to start with that number and then add on from that, if you can give me the next couple of years.

Dr. GRONVALL. I don't have at my fingertips a projection for '91, '92 and '93 of current service requirements based on $11.860 in 1990 as a starting point. I could supply that easily for the record.

Mr. PENNY. Then just do that for the committee because it is not only beneficial for you to get that on the record, but it's beneficial for us to know that. Because it's just ridiculous for us to tinker around with budget numbers on a year-by-year basis, especially when you're dealing with some thing as vital as health care for America's veterans. We have got to take the longer view here. So while we've got a real tussle on our hands to get a supplemental for this year and get some additional allocations for next year, we've got to know just how much we need to build on this $11.9 or whatever our final fiscal year 1990 number is in order to take care of those needs as that retirement population increases.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

The 1990 budget request that the VA submitted to the Office of Management and Budget for the Medical Care appropriation was $11.860 billion. Based on the 1990 funding level, future year resources requested were $12.280 billion in 1991, $12.811 billion in 1992, $13.21 billion in 1993, and $13.667 in 1994.

Mr. PENNY. Mr. Chairman, I had one other question I was going to ask, and I do have several others that I was going to submit for their written response. I'll just submit all of them for written response, if that's okay.

The **Chairman**. Without objection, so ordered.

[The questions and their response appear at p. 498.]

Mr. **Harvey**. Mr. Penny, may I just say that one convenient way to look at the question that you just asked, about the increased need in health care, the inflation factor for the health care industry is something just under 7 percent. I think if you took $11.9 billion and inflated that, compounded at 7 percent, it would give you some ballpark figures of where that growth probably ought to be going.

Our working in the health care industry, our cost of supplies, our cost of staff, our cost of most things, is pretty close to what the health care inflation figure is in America.

Dr. **Gronvall**. If I may comment, Mr. Chairman, that ties back to your opening comment about the aggregate cost increase of the medicare program. That program has been a part of the cost of care escalation in the country, however, the VA support year by year has lagged well behind the rate of increase in medical and health care generally.

The **Chairman**. Thank you.

Charlie Stenholm.

Mr. **Stenholm**. Thank you, Mr. Chairman.

That's precisely the point I wanted to follow up. First, though, an observation. I denote a much kinder, gentler message from Mr. Harvey than the printed text that we have before us, and we all appreciate that very much.

It's interesting to me to listen to the answers to my colleagues' questions concerning the problems with OMB. I'm going to ask is a little more elaboration on the studies and analysis that show that the VA delivers services more efficiently, than we are doing through our medicare/medicaid system. That's my question, but first some observations.

The letter from Secretary-designee Derwinski and your statements clearly acknowledge the need. And that need is there. The frustration that some of us who represent more rural areas find is that government by the numbers, produced by Gramm-Rudman and delivered by OMB is no way to run the country. But that's what we're doing now, because Gramm-Rudman demands that we do certain things.

Chairman Montgomgery has been very instrumental in a couple of areas which have been extremely helpful to us. The sharing of facilities with DOD makes good sense, and it has worked wonders in my district. Outreach centers are an excellent way to deliver the health care services to veterans more efficiently and get care to more veterans. In a very rural area, where we have miles to travel, both of these programs have worked wonderfully for us.

But now we find, because of the budget squeeze, that we're in danger of having to shut down the outreach centers because there is no money. There are no dollars to do it, even though it has been proven by your facts and figures that it's the most efficient way to deliver it.

You mentioned the cost difference for educational programs. The largest private-sector hospital in my district is quitting their educational program because they can't afford it any more. This year they will bill $47 million on medicare and they will collect $20 million. They will not collect $27 million because budget by the numbers is saying through the DRG system that you've got to do it $27 million cheaper.

I guess it goes back to the question of what do we have to do, or what should you be doing that you're not doing, to bring the information? What studies do you have to show to OMB and the folks with the green eye-shades that you're a part of a system that is delivering health care to veterans cheaper. Where are you failing in getting that information to OMB?

Mr. **Harvey**. I think there are a couple of areas here. One of the problems that I believe—and I honestly haven't discussed this with any one individual at OMB—a professional at OMB has to deal with is aggregating all of these things that we're talking about. He is not just thinking of Veterans' Administration health care. We are $11 billion out of a $500 billion a year industry. We're a small part of that overall. So someone at the Health Care Finance Administration is trying to aggregate all of the other different health care providers.

As they do that, they come up with numbers, like there's an excess of about a quarter-of-a-million hospital beds in the United States, in gross terms. In Baltimore, a few years ago, the State accrediting agency was attempting to close one of the four hospitals in Baltimore because they said the area was over-bedded, and by having that extra layer of overhead because of that extra hospital, it was just wasteful. So if you close one hospital, you could do everything separately.

The Veterans' Administration built a new hospital in Baltimore. Was that a good idea or not? I wasn't around to participate in the decision. Quite frankly, if you were looking at that problem in aggregate terms, you may well say is this the place where we ought to be building a new hospital, in spite of whatever the political pressures are, in spite of all these other things?

So I think the people in OMB are persons of good will, who have a very difficult job themselves. By definition, they're sitting in an office down there attempting to deal in aggregates. I think that probably the Veterans' Administration, being in the Cabinet and an active advocate like Secretary-designate Derwinski sitting at that table, I have an idea he will make our cause heard more legibly perhaps than it has at times in the past.

Mr. **Stenholm**. I fully expect that. I certainly did not mean to imply that there's a lot of money out there for health care, because there is not. We're shutting hospitals down at alarming rates now in rural areas, and maybe some of them we ought to be shut down, quite frankly, if the taxpayer is not willing to fund them locally.

We must look for ways to include the VA's problems with the rural problem, with the urban problem, and somehow, some way, arrive at the right amount of money. You can appropriate more to solve the problem, you can get more efficient, or you can do both. I think we're at the stage where we've got to do both. To appropriate more, that means we've got to get into the lip reading, and that's going to get a little tough down the line.

I would like to see a listing of the DRGs, the urban/rural bias, and where VA fits in that. I would like to see that.

Could you furnish that for us for the record?

Dr. Gronvall. Yes, sir.

Mr. Stenholm. I would very much like to see that.

Thank you, Mr. Chairman.

(Subsequently, the Veterans Administration furnished the following information:)

The Department of Veterans Affairs uses the same DRGs as HCFA. However, the VA does not make budget distributions based on DRGs relative to the rural/urban location of a VA Medical Center. We have no evidence to indicate such an adjustment is necessary for VA facilities.

[A listing of the DRGs used by the Department of Veterans Affairs appears on p. 129.]

The Chairman. Thank you, Charlie.

Also, Dr. Gronvall, before we call up our next panel, to follow up on that, it looks to me like you need to come up with some study about VA hospital care versus private hospitals and public hospitals, the cost per day. You know, a fair study would help us and it might help us with OMB if we do find out we can treat patients at a lower rate than under medicaid or medicare. Just a study, unless you can give us the exact figures on it.

Dr. Gronvall. Mr. Chairman, we have a study that was completed about a year-and-a-half ago that compared the total cost of treating a given illness in the VA using the DRG nomenclature, to the cost of treatment through the medicare program and in a couple of State-supported programs. We have that report available. That was the basis for my statement that the evidence shows that the VA, in fact, is more economical than other hospitals.

The Chairman. Did you include the sharing agreements in that study?

Dr. Gronvall. What we documented was the cost per case of a patient cared for in our hospital and didn't dissect the source of funds. If patients were cared for through a sharing agreement, they would have been in the study and documented on that basis.

The Chairman. I don't know. That's not a very clear answer to me.

Would you mind going back and looking at it and see if you can come up with——

Dr. Gronvall. We will supply a copy of the report to the committee and a commentary on the study.

(Subsequently, the Department of Veterans Affairs submitted the following information:)

In May 1986, the Department of Medicine and Surgery released a report of a study comparing the average cost of an episode of acute care in the VA to the average cost of treating similar patients in the private sector. This study had been requested by the White House Working Group on Health Policy and Economics. The charge specified that the study assess both costs to the Federal Government and costs to society.

Earlier cost comparisons, which were based on estimating the cost of a bed day of care, could not adequately address differences in case mix among VA and non-VA hospitals. However, the development and subsequent use of the diagnosis related group (DRG) made it possible to classify patients into distinct groups and compare the costs of treating them in different environments. The comparison data comprised Medicare, Medicaid, California, and Maryland hospital charges by DRG; Medicare and Medicaid reimbursements by DRG; and estimates of actual costs by DRG from Maryland and a large New England teaching hospital.

The calculated VA average cost per case-mix adjusted case accounted for all factors related to patient care except for physician salaries. These were excluded because the private sector treats physician fees separately from hospital charges, and physician payments cannot be related to an episode of hospital care. The VA average cost was adjusted for capital and other unfunded VA costs and, to the extent possible, other adjustments were made to improve comparability among the data bases.

The study included all acute-care discharges in FY 1984. These would include any patients admitted under DoD sharing agreements as well as all eligible veterans. Since the study only differentiated among patients on the basis of DRG, not on eligibility or reason for admission to a VA hospital, that segment of the patient population cannot be pinpointed at this time. However, the basis for these sharing agreements is that they will be mutually advantageous; therefore the military would not enter into an agreement to use VA services if the same services were available at a lower cost in the marketplace.

Comparisons were made at the national, regional, or local level depending on the geographic area encompassed by the non-VA data. The findings showed that the VA cost per case was substantially less than private-sector hospitals were charging, except the average charge in Utah. Where actual cost data were available, the VA cost was less than the Northeast teaching hospital and approximately the same as the State of Maryland. Although VA costs were higher than Medicare reimbursements to facilities it should be noted that these Medicare reimbursements do not include deductibles and copayments. While it was not possible to obtain an accurate estimate of how much these payments would have added to the Medicare average reimbursement per case, it is clear that the difference between Medicare average payments and VA costs was substantially less than the data indicate. Furthermore, while deductibles are not costs to the Federal Government, they are nevertheless costs to society because they must be paid by patients, their families, or other third-party payers or they must be absorbed by the provided.

[A copy of the entire study appears on p. 134.]

The CHAIRMAN. Before yielding to Dr. Rowland, we keep getting this slowing down of funding recommended by OMB, these across-the-board cuts. It would seem to me that you're going to have to change some missions and you're going to have to close some more beds and some more VA hospitals, is that correct?

Dr. GRONVALL. Yes.

The CHAIRMAN. That's serious.

Dr. Rowland.

Dr. ROWLAND OF GEORGIA. Mr. Chairman, let me tell you how pleased I am in the direction the questioning has taken here this morning, comparing the VA health care delivery system with our health care delivery system in the country as a whole, because I have contended for several years now that quality care can be delivered much cheaper, must less expensive, than it is being delivered under the medicare/medicaid system. I have felt that the VA offered a model or prototype to be looked at to make some changes in our entire health care delivery system. So the line of questioning and the answers that have come in this morning are really very good.

It is difficult to make this comparison. I have tried to get this comparison over the past 3 years. It is hard to make the comparison between the VA and the private sector. But I'm continuing to try to get that information and I certainly would look forward to working with you, Dr. Gronvall. Vic Raymond and I have been discussing this at some length.

Let me just make one other observation about the productivity improvement cuts. This tour of hospitals that I made last year, every director, that was the first thing that they mentioned that was most distasteful to them. The harder they worked to increase their efficiency, the more they were penalized for having done that. It reminds me of patients I had when I was in private practice who worked in shirt factories. They were given a quota to meet, and all above the quota they produced, they were paid extra. So the people that ran the factory raised the quota. Then they worked harder to get above that quota. Finally, these ladies working there would come in and say they're nervous. I would ask what are you nervous about? Well, I can't beat my quota now. I need something to help my nerves.

Well, I think the directors in the Veterans' Administration hospitals have the same problem. They need something to help their nerves. I think the best thing that could help their nerves is to stop these ridiculous productivity improvement cuts.

Thank you.

Mr. PENNY [presiding]. I don't think any response is necessary to that. I think most Members of the committee would affirm that they're hearing the same thing from their VA Medical Center directors. I would hope the VA Central Office would be sensitive to that concern.

Lane Evans had a couple more questions and then we're going to move on to the next panel.

Mr. EVANS. Thank you, Mr. Chairman. I beg the indulgence of the committee and the panel.

Can you tell us what the amounts of funding in this year and last year were for prosthetic equipment?

Dr. GRONVALL. Let me supply that for the record. I don't have the detailed breakdown within the budget, but we will supply it for the record.

(Subsequently, the Department of Veterans Affairs submitted the following information:)

Total prosthetic funding includes costs for prosthetic appliances, sensory aids, dental prosthetics, medical accessories, etc . . . , and the repair and upkeep of such items. The 1988 obligation for prosthetic supplies and equipment was $98,392,000, and for the 1989 estimated obligations are $104,748,000. The 1988 obligations for repairs to prosthetic appliances was $10,251,000, and the 1989 estimated obligations are $10,876,000.

Mr. EVANS. Do you know if the Veterans' Administration is experiencing shortfalls in the funding for such equipment? I am told by several veterans that there are long delays from the application and order for equipment until the filling of those orders.

Dr. GRONVALL. Yes, that's correct. As a part of the general tightness of the budget this year, that problem is even worse.

Mr. EVANS. Is it possible to provide us after the hearing with what might be an average waiting period for a person, or give us some kind of statistical information about how long these waiting periods are?

Dr. GRONVALL. Yes, we can do that because that's been studied during this most recent year.

Mr. EVANS. Thank you.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

Of the 168 VA Medical Centers responding to a field survey by a Prosthetic Task Force established to review the adequacy of the funding of the Prosthetic Program in FY 1988:

89 (53%) VAMCs reported delays in providing prosthetic services.
79 (47%) cited funding problems as the primary cause for delays.
7,552 orders were delayed due to funding problems.

Data is not available concerning the average amount of time of a delay. However, based upon the complaints received, delays of 3 to 4 months have been occurring. These problems are expected to continue in FY 1989. VA Medical Center Directors have projected a $10.6 million shortfall for providing prosthetic services in FY 1989.

Mr. PENNY. With that, we want to thank the panel for your testimony this morning and for answering the many questions that Members had.

We want to call forward the next panel, but before you leave the table, I would urge Mr. Harvey, Dr. Gronvall, Mr. Vogel, Mr. Hoffman and others from the VA to stay and give the veterans' organizations the courtesy of your attention.

Now we will call forward the next panel for the presentation of a proposed Independent Budget, which has been compiled by the Paralyzed Veterans of America, the Disabled American Veterans, the Veterans of Foreign Wars, and AMVETS.

While the witnesses are coming to the table, I would like to convey our sincere appreciation for the many hours of work and the expense involved in putting together this proposal.

Witnesses for these four major veterans' organizations include Mr. Jack Powell of PVA, Mr. David Gorman of the DAV, Mr. James Magill of the VFW, and Mr. Noel Woosley of AMVETS. We will start in any order that you prefer. I assume, since you have worked so closely on this, you may have decided ahead of time the order in which you want to make these presentations. So you may proceed as you wish.

STATEMENTS OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; NOEL C. WOOSLEY, NATIONAL SERVICE DIRECTOR, AMVETS; AND JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman.

I would like to begin by extending our sincere appreciation for the opportunity to present our views regarding the budget requirements of the Department of Veterans Affairs for fiscal year 1990. Also, as this year's Chair of the Independent Budget, the DAV welcomes the opportunity to join with our fellow veterans' service organizations today for the purpose of discussing that document.

As you may be aware, Mr. Chairman, each of our organizations has taken general responsibility for a single element of the Independent Budget. DAV's responsibility is in the benefit programs and general operating expenses, the AMVETS is responsible for the national cemetery system, the Paralyzed Veterans of America has the medical budget, and the VFW is responsible for the construction component.

["The Need Is Now—An Independent Budget, by Veterans, for Veterans Programs," appears on p. 202.]

Mr. **Gorman**. At this point, Mr. Chairman, I would like to use the remainder of my time in discussing our analysis and recommendations pertaining to the Veterans' Benefits Administration.

Firstly, Mr. Chairman, a basic cornerstone of our budget document encompasses a revision of the VA's methodology employed in their basic budget formulation process. Our assessment of the administration's budget is that it has been formulated without any concern for addressing the real needs of veterans, and the process no longer has a goal of assessing the resources needed to deliver Congressionally mandated benefits to veterans in a timely and quality fashion.

Our blueprint for responsible budget formulation is described in some detail in the Independent Budget document.

It is beyond dispute that service to veterans is woefully inadequate at this time. In the Compensation, Pension, and Education Service, only 28 percent of original compensation claims were completed within 90 days where VA standards call for a goal of a 50-percent completion rate.

By October of 1989, the pending compensation and pension cases will have more than quadrupled to 683,451 from the October 1987 level of 167,687.

A significant increase in the substantive error rate has also occurred. Over one million telephone calls go unanswered on a yearly basis.

Successful rehabilitation time of veterans has increased by 65 percent since 1984, up to 255 days from the 1984 level of 155 days. Veterans must now wait an average of 90 days for an initial vocational rehabilitation interview.

There is routine use of adjudication and supervisory personnel to perform simple clerical tasks.

The Loan Guaranty Program is witnessing such major problems as decreased cure rates of loans in default, issuance of bad loans, poor appraisal practices, poor maintenance of foreclosed homes, and poor marketing techniques.

Frankly, Mr. Chairman, our best judgment is that the lack of timely and quality delivery of services to veterans is directly traceable and attributable to an inadequate number of full-time employees.

In order to reverse the trend of accelerating deterioration of services, we recommend a fiscal year 1989 supplemental totaling $23.9 million, which would provide an increase of 130 FTEE's in veterans' services, an increase of 200 FTEE's in CP&E service, an increase of some 140 FTEE's in loan guaranty, an increase of 61 FTEE's in vocational rehabilitation, 15 full-time employees to form a centralized training staff, and $15 million for enhancement of the VA's computer systems.

For fiscal year 1990, we recommend an increase of 250 employees in the CP&E service and staffing of the administrative function of support services be maintained at the fiscal year 1988 level of 1,536.

With these employment levels in place, we are confident that positive results will emerge, such as to reduce the abandoned call rate from the current 9 percent to only 2 percent by the end of fiscal year 1990, to reduce the pending compensation and pension work load to fiscal year 1987 levels, to meet the time limit standards established by the agency, to improve the cure rate of home loans to the fiscal year 1983 level of 85 percent versus only 77 percent in fiscal year 1987, and to reduce the vocational rehabilitation specialists' and the counseling psychologists' case loads to realistic and manageable levels which will enhance the successful rehabilitation of disabled veterans.

Mr. Chairman, this concludes my portion of the testimony, and with your permission I would like to turn it over to Mr. Powell to summarize the medical care budget, and then Mr. Woosley to do memorial affairs, and Mr. Magill for the construction portion of the budget.

[The prepared statement of Mr. Gorman appears on p. 310.]

Mr. PENNY. That is fine. We will take everyone in that order.

Mr. Powell.

STATEMENT OF R. JACK POWELL

Mr. POWELL. Thank you, sir.

I feel like, after listening to the first 2½ hours of this hearing, I'm carrying coals to Newcastle. Clearly the sense of the problem and the depth of the problem is understood by the Members of this committee, listening to the way they talk.

In 1980, documents surfaced from the Office of Management and Budget which stated very clearly their rationale in proposing the first massive reductions in the VA health care funding. Those documents stated that the objective was to—and this is a quote from those documents—"shrink the VA system size slowly." I think the fact that we are here today shows that that intention, that goal, that objective, has never changed one iota in the last 9 years. Clearly they have been successful, much more successful than those of us who care about veterans' health care have been in providing additional funding.

The Independent Budget estimates the shortfall in this fiscal year, 1989, is approximately $1 billion. That includes medical equipment that hasn't been purchased, and maintenance. With that kind of care, Mr. Stump, I don't know how $25 million adds up to $500 million, but that is what their lists show. I heard the answer to your question earlier. I am kind of amazed. I guess you can do anything with numbers.

We also were amazed at the timing in which the supplemental request was delivered here today asking for $314 million. That is about $100 million less than what we recommended in the Independent Budget as a supplemental for the fiscal year 1989 budget. We recommend $410 million this year in supplemental, which would just about make up that difference in the VA's own admitted shortfall of some $625 million. The numbers are also clear, and you have the Independent Budget before you.

I would like to respond to a few other things, questions that I heard from various Members. Sometimes, at least, I get confused in the voluminousness of the answers.

Clearly, we are in a time in which money alone is not enough, and clearly we have to have some other options. We have to have some other aspects. One of them is called management, just plain, simple, intelligent, rational, logical management. You don't have to be a rocket scientist, but we need some management considerations.

When we talk about the health care professions being 150,000 nurses short, that is going to be a problem. The question is then, what is the VA, that vaunts itself as the largest single provider of health care training and education in this country, doing to ameliorate that problem?

I am the hard-headed guy who said let's start talking about shutting down affiliations with medical schools that close down nursing schools, since that's what we really need; let's talk about looking at 2-year degree programs as opposed to simply 4-year programs and do more nurses and more nursing students with the same amount of money than we now spend on 4 years and get them a lot sooner.

We talk about productivity situations, we talk about retaining nurses. The simple fact is this: Right in Washington, D.C., at the VA Medical Center, the number of nurses or staff to patients is 0.5:1. In the civilian hospitals, at the same medical complex that the VA is located in, the staffing ratio is 1.2:1. It is not just paying competitive salaries, it is making the work that has to be done the same quantity of work that that a nurse can do if she walks right out of that hospital and into the hospital across the street. It is the same little compound there for anybody that is familiar with.

We talk about child care, and certainly that is an important issue, but I just came from Tampa VA Medical Center last Friday. Let me tell you, down there, to do a physical exam on patients on the spinal cord injury service, they either have to wait for the personal care clinic to be closed so they can put the patient on a gurney, or they have to do it on an empty bed in a room if they are fortunate enough to have one. They don't even have an examining room down there large enough to get a patient in in a wheelchair or on a gurney in that hospital. There has been an SCI center down there for over a decade. If we don't have space to do a physical exam on a patient some place other than in a hallway with people passing up and down, how in the world are we ever going to have the space to provide a day-care center?

We talk about homelessness and that being a national issue in this country, and the VA's response is to propose a budget that reduces—closes domiciliary beds. Domiciliary beds are a provider of care for homeless people. So the response of Government to an identified national problem is to make the problem greater rather than smaller. Maybe if it costs more we will pay more attention to it.

We hear hospital directors talking to Members of Congress and others about flexibility. Our Independent Budget specifically on medical and prosthetics—specifically on a prosthetics line item, talks about making that a specific line item. That is directly in the face of flexibility. The reason is that hospital directors have been forced by a lack of money to rob Peter to pay Paul, and Peter is broke, so there ain't no money left to rob from him. So what we end up with is an inordinate waiting time for prosthetics.

I called the Administrator about 6 months ago—because he always said, "Tell me if you have got a problem"—about a service-connected veteran statutorily entitled to a wheelchair, a paraplegic, and said, "This veteran has been denied his chair. What can you do?" They said, "Well, we'll get back to you." The next day they called back, and they said, "He is no longer denied." I said, "Well, that's wonderful. When does he get his chair?" "Oh, as soon as we get money." If you are a paraplegic being approved for a chair and not getting the chair, it doesn't make much difference one way or the other.

There are many, many problems. The numbers are all recommended in the budget, but they will take not simply dollar funding, they will take the establishment of some sense of priority, some sense of mission for the agency, that we then work towards, that all of us can understand.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Powell appears on p. 323.]

Mr. PENNY. Thank you, Jack.

Mr. Woosley.

STATEMENT OF NOEL C. WOOSLEY

Mr. WOOSLEY. Mr. Chairman and Members of the committee, thank you very much for this opportunity.

AMVETS, as a member of this panel, will be commenting on the Department of Memorial Affairs. The veterans' service organizations believe that this component is doing a good job in meeting the current needs. The fiscal year 1989 budget justification for this account is a good example of reasonable budget formulation. The VSO's believe that the Administrator's fiscal year 1990 budget request for 35 additional FTEE's at a cost of $3.2 million is adequate for this well run department to meet the short-term needs of veterans.

However, based on information supplied by the Veterans' Administration, the following facts are directly relevant in long-term budget needs. There are currently more than 1.1 million veterans who are 75 years of age or older. Current estimates show 126,000 World War I veterans with a median age of 91 and 9,606,000 World War II veterans with a median age of 66.

The following States have no national cemeteries: Connecticut, Delaware, Ohio, Montana, Nevada, New Hampshire, the District of Columbia, North Dakota, Rhode Island, Utah, Vermont, Washington, and Wyoming.

The following States have cemeteries which are closed: Arizona, Georgia, Maine, Maryland, and New Jersey. These closed cemeteries can accept the remains of cremated veterans.

Through 1989, 51 of the 112 operating national cemeteries will be closed to new internments; 19 States at that time will have no national cemeteries or have cemeteries closed to new internments.

From 1990 to 1994, two new cemeteries will open, but an additional ten cemeteries will be closed, and by the turn of the century eight more will close. In other words, by the year 2000, based on current DBB projections, only 45 cemeteries will be open to internments.

These facts are disturbing to the VSO's in view of the aging veteran population and the obvious need for a greatly increased number of grave sites in national cemeteries in the not too distant future.

The rest of my text, of course, you have in front of you, but one interesting point that was made today was the closing of military bases. In our proposed Independent Budget, we suggest the VA may well have to buy land in order to acquire it. Perhaps some of these bases could afford us new cemeteries or grave sites.

This concludes my testimony, Mr. Chairman.

[The prepared statement of Mr. Woosley appears on p. 332.]

Mr. PENNY. Thank you.

Mr. Magill.

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you.

Before I go into the construction aspects, I would like to just make a comment on the overall budget.

We have heard that the budget falls short. I think we all acknowledge that. What I would like to comment on that adds to this issue is the administration is calling for an appropriation of $900 million for credit reform. They are also calling for $900 million in appropriations for trust funds, which really do not require appropriations. So right there we are not talking, as the Administrator said in a briefing, that this is the largest budget ever. You can skim at least $2 billion right off the top of it.

This is not to take into account some of the other legislative proposals that I believe the Congress has rejected in the past.

With respect to the budget, we recommend a $922 million construction program appropriation for fiscal year 1990. Our total sum is almost twice the $488 million reflected in the President's FY 1990 budget. We believe about $635 million should be used for major construction and $275 million be used for minor construction, with $12 million earmarked for the relatively new revolving fund parking program.

The major portion of our major construction appropriation recommends $559 million should be used, as stated in the VA's construction requirements, cited in their own 5-year medical facilities development plan for fiscal year 1990.

The next largest recommended appropriation is $40 million for the advanced planning fund and design fund. The purpose of these two closely-related funds is to allow projects to proceed in an expeditious and cost-effective manner through the planning and design stages of the construction process. This represents some $15 million more than the approximate $25 million the VA has requested. We believe ours is a more rational figure to begin to accelerate the historically lethargic 10-year construction process.

Our next major construction program deals with nursing homes. This is a very significant item and we believe $30 million is the absolute minimum required to fund four new facilities of 120 beds each.

We can foresee a need to build four new VA nursing homes each year for the next several years of this coming decade. This must be done in conjunction with the earlier request to have the VA convert 1,000 existing hospital beds to nursing home beds each and every year through the 1990s, starting with a one-time conversion of about 2,000 such beds.

The primary intent of the $275 million of minor construction funds is to ensure that the entire VA system is maintained in a good state of repair. $200 million is identified for medical construction minor projects, with $40 million specifically set aside for the conversion of the existing medical center space to the nursing home use exclusively. This estimated $40 million should be sufficient to permit the conversion of the previously mentioned 2,000 bed spaces to nursing home care this fiscal year.

This wraps up my portion of it. It is detailed in our budget book. Thank you very much.

[The prepared statement of James N. Magill appears at p. 346.]

Mr. PENNY. Thank you very much.

Since I'm chairing now, I don't have to wait my turn; is that right?

[Laughter.]

I rather like this.

The CHAIRMAN. I hope you don't like it too much.

[Laughter.]

Mr. PENNY. Mr. Chairman, I want you to stay in this chair as long as you want to stay in Congress. I'm happy with the subcommittee chairmanship for now. But it isn't bad to sit up here once in a while in your place.

I want to ask some general questions about your attitude about the new VA Secretary and what kind of relationship do you think you're going to have in the future. You might want to relate that to the kind of relationship all of us have had over the last several years. Any early observations?

Mr. MAGILL. We, of course, as we have in the past, will work with the gentleman in this spot very well. We, of course, will be watching him very, very closely. I might add that we were very encouraged that Mr. Derwinski has initiated several calls to us wanting to meet with us to find out our concerns. We find this very encouraging. The hearing process, as you know, was postponed. It was scheduled for Monday. We are looking forward to going over at the confirmation hearing.

Again, we will work with him very closely and support him, as long as he is an advocate of the veteran. This is our main concern. We need somebody in that position that will come up and fight for a budget that will do the VA justice.

Thank you.

Mr. PENNY. Do any of the others want to respond?

Mr. GORMAN. Mr. Chairman, the DAV has met on two occasions with the Secretary-designee, and we have walked away from both those meetings rather pleased and optimistic. I think it's a breath of fresh air to see the openness that he has displayed and the willingness to work with not only the veterans organizations but with the Congress and how the process works, the consideration that we're all players in the same game and the involvement of all the players is necessary to get the job done. That might be evidenced by the timely submission of that correspondence this morning to the committee.

Mr. POWELL. Mr. Chairman, certainly we're glad to see that there's a Secretary of Veterans Affairs, number one, and we thank this committee for their tremendous work on that.

I tried to stay off the numbers, because we're so familiar with the numbers, when I had my little bit on the budget, and I wanted to talk a little bit about management. The thing that most greatly concerns me is that we now know who the Secretary-designee is, we now know who the Deputy Secretary-designee is. And while both of them are undoubtedly distinguished gentlemen, and certainly nobody can quibble with the Secretary-designee's experience with Congress and Capitol Hill, neither one of them have much in the way of a management background to recommend them.

I point out to you the size of this agency, the depth of its problems. So our greatest concern, frankly, is what will the Secretary and the Deputy Secretary designees do to bring in extremely competent managers into that next level, which is the level that we're left dealing with.

You know, if the VA's insurance programs or benefits programs were a separate insurance company trying to do business in a State, the insurance commissioner of any State in this country would throw them out. We just don't accept in a State that kind of time to process a death benefit from an insurance company when somebody dies, or that kind of time to pay off in the case of an automobile accident or what have you. But that's taken for granted here.

Maybe sometimes it isn't always bad that we've got flexibility in this new law to go outside of the system. I would certainly encourage the new Secretary to look for competence, whether it comes from within the system or outside the system. But what he needs is managers.

Mr. WOOSLEY. Mr. Chairman, our organization has also met with the new Secretary-designate, and we felt very comfortable in our meeting. He set aside the time and he used terms like, if it works, we won't fix it, but if it doesn't work, you can bet I'll fix it. So maybe that will relieve some of Jack's concerns.

Mr. PENNY. I thank you for that.

I really want to stress the appreciation of this committee for the fine work that your organizations have done in putting together this document. It's not an easy undertaking. The effort that your organizations put toward this project is commendable. Your expertise is vital. This document is going to be a tremendous asset to us as we sort through those funding needs, both this year and for the years down the line.

I just want each and every one of you to convey to your staff and your Members that a committee of Congress is greatly indebted to you for your willingness to put in this kind of effort.

Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

I would like to add my thanks, too, for all the work and effort that you have put into this Independent Budget. I think, with your help and the help of your organizations, perhaps this committee can do something about turning some of these things around.

Thanks again for all your hard work and your testimony here today.

I yield to the Chairman.

The **Chairman**. There's nobody in the chair.

[Laughter.]

Mr. **Harris** [presiding]. Mr. Chairman.

The **Chairman**. Thank you, Mr. Chairman.

I would like to add to what Tim Penny and Bob Stump said, to thank these veterans organizations for taking of your time and funds to give us an Independent Budget that we can compare with the budget that has been submitted so far by the Reagan administration. It is very helpful to us to have these comparisons. Quite honestly, we don't have enough staff to do this work ourselves. I know last year we spent a lot of time comparing your budget with the budget that was sent up here pertaining to veterans.

Again, I want to emphasize what I said earlier today. We really need your help. We do good in this room, but you get outside of this room and then we've got a lot of problems. I hate to admit it, but we've got groups out there that sometimes are more powerful than we are. We have lost amendments over on the Senate side for VA medical care versus something else in the Government, and we got whipped over there. I worry about that. So we have a lot of work to do, and if we're going to get a decent budget, you have to send the word out across the country.

We're not asking for too much. The cost of the B-1 bomber keeps going up. We're asking, before we get through paying on a B-1 bomber, less than one B-1 bomber on a supplemental to take care of veterans and keep these hospitals and outpatient clinics open. So what we're doing is not unreasonable is what I'm saying.

Thank you, Mr. Chairman.

Mr. **Harris**. Thank you, General.

Mr. Stump.

Mr. **Stump**. Mr. Chairman, I would ask unanimous consent that the statements of Mr. Hammerschmidt, Chris Smith, and Mike Bilirakis be inserted in the record today.

Mr. **Harris**. They will be inserted.

[The statements of Hon. John Paul Hammerschmidt, Hon. Christopher Smith, and Hon. Mike Bilirakis appear at pp. 338, 340 and 341.]

Mr. **Harris**. General, I don't have any statement, other than I would like to commend the organizations before us for their approach to this budget, especially the breaking down in particular areas. That gives each one of you more time to reflect on that and it helps us in trying to go about this budget process. I certainly appreciate it, and I know I speak for the rest of the committee when I say that.

Mr. Chairman, did you have something else?

The **Chairman**. Yes, thank you.

Claude, I would like to submit for the record, if I may, a letter from the Chief Medical Director, in which he lays out the funding requirements for a balanced medical program based on the mandated staff of 174,000 personnel. I would like to submit that letter from Dr. Gronvall.

The **Chairman**. Without objection, it will be made a part of the record.

[The letter appears at p. 192.]

The **Chairman**. That's all I have.

Mr. **Harris**. Unless there is something else from the panel, this will conclude the hearing for today. I thank all the people who participated. It has certainly been helpful to us.

[Whereupon, at 12:05 p.m., the committee was adjourned.]

FISCAL YEAR 1990 VA BUDGET

Wednesday, February 9, 1989

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D. C.

The committee met at 9 a.m. in room 334 of the Cannon House Office Building, the Honorable G.V. (Sonny) Montgomery, chairman of the committee, presiding.

Present: Representatives Montgomery, Applegate, Evans, Penny, Rowland of Georgia, Stenholm, Harris, Kennedy, Johnson, Jontz, Payne, Sangmeister, Parker, Jones, Stump, Hammerschmidt, Wylie, Smith, Bilirakis, Ridge, Rowland of Connecticut and James.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The. Chairman. The committee will come to order.

About half the Members of the Veterans' Affairs Committee all go to the House Prayer Breakfast Group. We broke up the House Prayer Breakfast a little bit earlier this morning by having this meeting at 9 o'clock.

The committee will be in order, and we will begin the second day of hearings on the VA's proposed budget for fiscal 1990.

On Tuesday, we heard from the VA officials, an Independent Budget panel consisting of AmVets, Disabled American Veterans and the Veterans of Foreign Wars. They presented the Independent Budget which helped us very much.

Today, we will hear from the Honorable Wes Watkins, our colleague from Oklahoma; Dr. Kenneth Shine of the Association of American Medical Colleges; Dr. L. Thompson Bowles of the VA's Special Medical Advisory Group; the Nurses' Organization of the VA, the American Nurses' Association, and representatives of several veterans' organizations.

Our first witness will be the Honorable Wes Watkins from the 3rd District of Oklahoma. Wes is a member of the Appropriations Committee. We've been very happy, as I said, to have him in the Congressional Prayer Breakfast Group and as one of our leaders in the Congress. And, certainly, we appreciate, Wes, your being on the Appropriations Committee.

We can authorize, but if the funding is not there we can't do the things that need to be done.

Wes Watkins, glad for you to be here with us.

STATEMENT OF HON. WES WATKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. WATKINS. Thank you, Mr. Chairman, Members of the committee. I note you have a full schedule today and I want to honor your time and try to summarize my statement.

Mr. Chairman, I'd like to ask unanimous consent to make my formal statement part of the record and allow me to summarize it.

Mr. MONTGOMERY. Thank you, Wes.

Do you have any comments this morning, Mr. Stump?

Mr. STUMP. No, Mr. Chairman.

Mr. WATKINS. I would just say, if you would do what my prayer said this morning, I won't belabor anything in my testimony. And take care of the "least of my brothers and sisters", I'll get an out-patient clinic in my area.

Let me say this. I do know that you all have a tough job; I respect that so much. I think we all have in this Congress, Mr. Chairman. But I've come to appeal to you and plead with you, if I could.

I have a huge, sprawling district in the southern and eastern part of the State of Oklahoma. That's nothing new to Bob Stump because he's got one in Arizona. But, in my area, we have some retirement that's coming on. We have a very patriotic group of people.

I summarize a lot of my constituents as being God-fearing people, and they're very patriotic. But, many of these people have to go 200-some-odd miles to try to get any kind of veterans' care. They have made, believe me, a tremendous effort to bring to my attention the fact that they need some kind of out-patient care.

They are talking about it in Bryan County, Oklahoma, where I grew up as a boy. Durant's the county seat. Many of the people are very thankful for what they're able to get in veterans' care. When they go something like 150 or 200 miles away, many of them go there to sit all day long and to try to get some help. Some of them have to end up spending the night.

It seems to me it would be in our wisdom to try to establish some out-patient care areas to serve some of these gigantic, sprawling, highly-populated veterans' areas of our nation.

Like I say, we have in this area about 20 rurual-counties, Mr. Chairman. There's something like 60,000 veterans. And they have to go some 150-200 miles to try to get some type of care.

In Durant, there used to be what we call a rural hospital. It was modernized years ago. It's shared now with the Indian population.

Bob, you may be familiar with how some of that happens in your part of the country, too. But they would like to establish, and have appealed to me for several years now to do something about trying to get them some out-patient care. And I'd just like to ask, Mr. Chairman, you and the Members of this committee for your consideration and your vote on trying to help me get this established for these veterans.

John Paul Hammerschmidt is not here, but I'm thankful they're able to get over to Fort Smith, Arkansas and get a little help, but this area is over 200 miles from Fort Smith.

So I don't want to belabor it or burden you with a lot more facts and statistics about veterans. You know a lot more about veterans than I'll ever know, because you all are the authorities on them.

But I need your help to try to provide this service to them. So, Mr. Chairman, without anything more, I believe my official testimony is part of the record and I welcome any questions that you may have.

[The prepared statement of Congressman Watkins appears on p. 367.]

Mr. MONTGOMERY. Wes, I know you have two VA facilities in Oklahoma, one in Muskogee, Oklahoma and one in Oklahoma City.

How far is that?

Mr. WATKINS. A couple of hundred miles. About 175 miles from Oklahoma City. Muskogee would be further than that from my southern part of the district.

It takes 3 hours plus to get there.

Mr. MONTGOMERY. What would you like the committee to consider? An out-patient clinic?

Have they considered taking over a hospital that's not being fully utilized?

Mr. WATKINS. Yes, sir. A few years ago, they built a more modern hospital in this Bryan County area, and they've left a 125-bed hospital vacant there, a fairly good-shape hospital. The Choctaw Indians are utilizing a portion of that hospital, but there's definitely room enough that we could accommodate some of the veterans.

Let me tell you, I think all of you know, in today's circumstances, traveling 175-200 miles takes 3 hours plus. And the people, it really takes a big chunk out of a per capita income area of less than $10,000. And, you know, the veterans in that area get a lot less. They don't have any flexibility of revenue. They just don't have it.

And you've got constituents like that, too.

Mr. MONTGOMERY. Wes, I think it's marvelous that you have come to testify before this committee. I want to be fair though. I don't believe the VA is recommending that we authorize in the committee this year that particular project. We understand the Veterans' Administration requested $800 million for construction of VA facilities or improvements in out-patient clinics for this next fiscal year.

OMB cut that to less than $400 million. So, we've got some problems. That doesn't mean we can't get it done though. Plus, I'd like the new Members to know that it has been a problem trying to take over some hospitals that are not in full use now.

The VA standards are much different from the standards of private and public hospitals in different communities and States. We found out it's almost cheaper to go in there and rent facilities from somebody that will construct them and do them up to VA standards.

So I'm just saying I'm not trying to come into another hospital.

Mr. WATKINS. Mr. Chairman, we could take it if you want to lease it, rental-purchase or whatever, but we need the service.

I'm going to ask to meet with the veterans' staff or any other group, any of you on the staff, if they'll come to my area, study it and see what they can do.

I share what you're saying about the OMB and the tremendous cuts. But I know, in the wisdom of this Congress, we are not going to let the veterans surely continue to be sacrificed even greater. Many of them have already sacrificed more than most people.

Mr. MONTGOMERY. We certainly agree with you. The biggest problem we have is getting enough money to run our veterans' hospitals in this next year and they're talking about further closure of beds, closing some hospitals and changing the mission of the hospitals.

So we need your help, Wes.

Mr. WATKINS. That's the most ridiculous thing. We all know World War II veterans are hitting that age bracket now where they're going to need more mental and physical care than they've ever had because they are just hitting that stage of their life. We've got to try to take care of them either by building them or leasing them.

My colleague, Charlie Stenholm, and I have been trying to solve rural health care. Maybe the veterans could work with these rural hospitals and together serve the tremendous veterans' needs as well as working to solve some real problems.

Mr. MONTGOMERY. That's a good idea. We've got a lot of these rural hospitals. We certainly could look to a sharing program there.

Before yielding to Bob Stump, you are on the Appropriations Committee, we met with Bob Traxler yesterday, who is head of the HUD Independent Agencies, and my colleague. We will be submitting to the full Appropriations Committee to change the name of that Subcommittee. We are very proud of it—to VA-HUD and Independent Agencies. It will be known as the Veterans-HUD and Independent Agencies if the full committee votes it.

We are very proud of that because of our Cabinet status.

And one other point that you pointed out yesterday. There are other funds that come through the Appropriations Committee, like AIDS funds, a billion dollars, and it's divided. The VA didn't get any of that billion dollars for AIDS last year, and there will be another $1.6 billion, I believe, this year.

Wes, my point is our veterans' hospitals ought to get some of that money for treatment. Most of it goes into AIDS and to Health and Human Services. And we are treating more AIDS patients than any other group in the United States. We've got 9 percent of all the AIDS patients in our hospitals. We're not getting any of that extra money that will be allocated.

We can take some of that money for programs in the VA.

Mr. WATKINS. Mr. Chairman, it's a point well-taken. I can assure you I will check on that because, if we're not getting any of it, that's unfair.

Let me say I think all of us ought to recognize there's $1.7 billion being utilized on AIDS right now and no new revenue. We have to take that out of health care, health research, even some of the cancer research.

It may have actually been cut last year, I didn't check. And as you are indicating, there is another request for an additional billion or more on AIDS research. It's very much needed, but there's no new revenue. And if we don't get new revenue, we are going to continue to go right at the heart of the veterans' programs, the veterans' health care, rural health care. We've got to have either new revenue or we are just fooling and misleading the American people.

And I am raring to try to work with you to help solve that problem, to get new revenue, to put it in this program.

Mr. MONTGOMERY. I'm not blaming it on the Appropriations Committee. I just wish you would take a good, hard look at that program.

Mr. WATKINS. Under Gramm-Rudman, that takes us down to less than a hundred billion and no new revenue. When you absorb AIDS at 1.6 and with over 200 special programs, no new revenue; SDI, no new revenue; the Super Collider, no new revenue.

Mr. President, I would say I'll vote for any of them if you will give me the revenue so we don't have to cut the very heart out of all of these programs.

Mr. MONTGOMERY. That's a very good point. Thank you.

Mr. STUMP. Mr. Watkins, thank you for taking the time to come over to testify before this committee. You know this committee is very sympathetic to veterans' needs and you are well aware of the shortfall we have this year in the medical systems for the veterans.

But, rest assured, this committee is going to give you every consideration. In fact, we're going to probably come to you on Appropriations for some help in making up the funds that we don't have.

Mr. WATKINS. I figured this is not just for hearsay or taking up time. I'm getting the message, you know.

[Laughter.]

Mr. STUMP. Thank you.

Mr. MONTGOMERY. Sometimes, I wonder how many get the message.

Does anybody have any comments? We have a full panel today. Okay, Roy.

Dr. ROWLAND OF GEORGIA. Wes, thank you for coming and highlighting and focusing on the problem that we have been very much aware of that's happening in your district, too, and that you are dealing with on the Appropriations Committee, too.

So I think that all of us who are interested in this need to be as active as we can in talking with other Members of the Appropriations Committee, and pointing out to them the severe problems that are taking place.

We are going to hear testimony later on this morning about how the infrastructure in the Veterans' Administration is crumbling and how all health care is going to be jeopardized if we don't do something.

So let me encourage you, Wes, to talk with other Members of the Budget Committee and see if we can't stop some of the cuts that we've been having in health care, particularly.

Mr. WATKINS. Let me say, Roy, I deeply appreciate your very conscientious leadership in trying to solve health care problems in rural America for veterans and many others.

Let me say, veterans are directly in competition with the Space Program. When the Administration pushes for a space station, it's going to take $250 million more out of that. And with Gramm-Rudman, we've all got to look at it when Gramm-Rudman comes down below that. It will hold it down the next year further.

And when the new program comes on board, the veterans are competing with that administration's Space Program.

For instance, UDAGs under HUD are gone. The space station finally won out over the inner cities and tried to take care of those problems. We're not being able to do these other things because the space station and other things are winning.

I'm for the space station but, by gum, we're going to have to put some revenue in there if we're going to bring on a lot of new programs and reduce this deficit.

We're whistling Dixie, literally, in more ways than one if we don't do that. And when we vote for those budget cuts and vote for a budget to get down below Gramm-Rudman, then we're voting to cut the veterans' situation because we are voting right now with the space station.

And we are for it. Most of us in this room are for a space station. But you go out and see Bob Traxler. He had to give up a lot of things last year in order to accommodate the space station. And the Veterans' Administration is in direct competition with the space station. It's in direct competition with veterans because, under that allocation of appropriations—it's the same way in some of our areas. FDA, Mr. Chairman, has a great deal to do with AIDS and AIDS research. And the AIDS program, we are cutting some things in agricultural development because the FDA is part of that phase of the appropriations of the budget.

Mr. MONTGOMERY. Roy, may I follow up, and then I'll recognize John Paul.

We talked about Bob Traxler yesterday and we pointed out, and my constituents love the NASA programs, but they're adding $2 billion for a space platform that's been recommended by OMB to the Congress, an additional $2 billion to go into the Space Program.

And my point is to the veterans' organizations. Last year, we had an amendment that would transfer in the Senate some funds from NASA—not a whole lot, to the veterans' hospital programs. And DeConcini of Arizona offered an amendment on the floor over there to the effect the veterans versus NASA, and the amendment went down 70/30.

So the veterans' organizations have been trying to get to them. They'd better get the message. They do good in this room, but you get outside, they hit some real tough competition out there.

So, until the veterans' organizations get themselves totally organized and get to hitting other committees besides this one, we are going to have the same problems when we think we have a fair amendment to get more money. It didn't pass in the Senate last year.

Mr. WATKINS. Mr. Chairman, I would like to be supportive, like I said. I don't have that veterans' hospital in Muskogee, in the 2d District. I'm in the 3rd. I'll try to be as supportive as I possibly can because, like I say, someone in the far northeast tip of the State—I see John Paul, my colleague from west Arkansas is here.

And, John, I just express my thanks to that facility being up there in the far northeast because I'm getting people 200-some-odd miles from there who are trying to get out-patient roughly 200 miles from Fort Smith, to try to accommodate a large number of those people in the southern part of Oklahoma, the southern end, central part.

I'm trying to get—as supportive as I am for this because my veterans are hitting me over the head down there because they can't get any care, you know, without taking some type of full day or two days just to go get prescriptions filled.

Mr. **Montgomery**. John Paul.

Mr. **Hammerschmidt**. I just want to thank Wes for being here. I'm very familiar with the problems we have got because the entire eastern side of his district joins the southern part of my district. And I sympathize with him and want to be helpful to the proposal that he presents us this morning.

I also want to say, Mr. Chairman, that I have an organizing meeting in Public Works and Transportation in about 10 minutes, so I'll have to leave.

But, thank you very much, Wes.

Mr. **Watkins**. Thank you, John Paul.

Mr. **Montgomery**. Craig James.

Mr. **James**. Thank you very much. I just have a couple of questions for you.

What is happening in your district as far as projections? Are you increasing the number of veterans? The percentage increase is what I'm looking for.

Mr. **Watkins**. As I mentioned to you, because of some lakes in that part of the country, and we're increasing some retirement, and many of these are veterans. Many of them are veterans, believe it or not, who went to California and worked in the shipyards and they had 20 acres and a plot of land and they wanted to come back home.

And now they have come back home and they find that they don't have veterans' care.

Mr. **James**. What gross numbers or percentages in relationship to the anticipated increase compared from last year to this year?

Mr. **Watkins**. I don't have the percentage. It wouldn't be a large percentage of increase because we have a large percentage of veterans that have been living there for years that are reaching that age bracket now, so I don't have a large percentage of increases, like I say.

Mr. **James**. Do you know whether it's in fact an increase or in fact a decrease? Do you know?

Mr. **Watkins**. Some of my counties have had out-migration of young people for five decades of Okies and Arkies going to California trying to get a job. And I'm trying to do something about that. That's my whole life. I'm probably being obnoxious about rural America and rural development.

And we are turning some of those around, but a lot of these people who have lived there, they are now at the age where they have got to have veterans' care. They've never asked for anything before.

Now they find themselves having to drive close to 200 miles, so just a big influx. I keep saying we've had that amount.

Mr. JAMES. Thank you. One other question.

How does your district compare, or your area compare, statistically as far as decrease in real dollars from last year to this budgeted year?

What percentage does your district lose? Do you know?

Mr. WATKINS. I don't know. When I got here, I was the 4th poorest district in the United States of America.

Mr. JAMES. Do you know how it compares to the other districts?

Mr. WATKINS. When you say the fourth poorest district in the United States of America, that means that there's 431 others that are richer and have a higher per capita income.

Mr. JAMES. I should say region. I'm sorry.

Mr. WATKINS. Let me just show you. One of the best blessings you have sometime is in redistricting. I gave up a bunch of counties and now I'm just the twelfth poorest county in the United States of America.

I've done a lot while I've been here for my district.

Mr. JAMES. I'm sorry. I'm really talking about regions of the Veterans' Administration, the 27 regions.

Mr. WATKINS. Of the veterans' regions? I don't know. I do not have that statistic on that.

Mr. JAMES. Do you know who does in your region?

Mr. WATKINS. I'll bet the staff probably has something along that line.

Mr. JAMES. Thank you so very much.

Mr. MONTGOMERY. Thank you.

Let me recognize the gentleman from Florida.

Mr. BILIRAKIS. I'll be glad to yield to Mr. Applegate, sir.

Mr. APPLEGATE. I'll go after Wes.

Mr. BILIRAKIS. Just very quickly, you're on the committee, Wes. Veterans' Affairs has been added to the title HUD and Related Agencies.

Mr. MONTGOMERY. We hope so.

Mr. BILIRAKIS. Is that going to change the Appropriations picture in terms of who we complain to, to use Wes' words? Apparently, now the Appropriations Committee is competing and veterans are competing directly with some of these other groups.

Is that going to change right now?

Mr. WATKINS. Right now, you have HUD and Independent Agencies, and VA is one of the Independent Agencies. So, because, as Mr. Chairman said, they have elevated that to the Cabinet, they'll probably include that in the title and remove it from the Independent Agencies, so to speak.

Mr. BILIRAKIS. But, in terms of the appropriation process and in terms of who the VA is competing with as far as money is concerned, it's going to remain the same?

Mr. WATKINS. It will not, unfortunately. We are all in this game together as far as the competition under HUD and Independent Agencies, or VA, HUD and Independent Agencies.

There's going to be that category that's going to be competing with the space station, the urban inner-cities. That's where your chunk of money is that you're going to be competing against, like over in Ag and Rural Development.

Like I say, we have FDA and all these things we find we are competing against. And we're cutting out some Ag research stuff and other areas to try to meet the needs, and rightly so.

So we've got to come up with more revenue with Gramm-Rudman bringing us down, we're going to see cuts right at those programs.

Mr. **Bilirakis**. I'm wondering if now the improved stature of the VA, if there isn't something we can do with the administration, I mean, the appropriations process in terms of maybe spinning the VA off to some of those other areas.

Mr. **Watkins**. That's what the Chairman is doing right now. He's making sure he's getting the point across. But I think the VA Cabinet level will lift the profile of veterans' status and the veterans' dilemma in this country a great deal more.

But, if there's no money there—the past administration wanted a space station and they've got the funding for a space station, but they took the money out of the veterans' programs. I mean, that's just a fact.

We can't get around it. We are competing for that same dollar in that area, or that category. And we've got to get money if we're going to have new programs. You can't absorb all the new programs, and they've reduced the deficit down below Gramm-Rudman. We're having a mammoth meat ax going at these programs.

And, Mr. Chairman, kiddingly, I say I got into Appropriations just as we ran out of money. That's not a good time to be there, I guarantee you. You'd like to be there when it's going like that, but when you're going like this, it makes it difficult.

Mr. **Bilirakis**. Over the past number of years, the dollars that have gone to veterans' programs have been considerably less than they have been in terms of the increase of spending.

This is not necessarily true for the last 3 or 4 years, because of Gramm-Rudman. Mr. Chairman, I hate to hear Wes talk about competing with the space station when we know that the dollars are competing with an awful lot of programs, social programs and otherwise—certainly, all of which, I suppose in a sense—have merit. The curves continue to go up in terms of poverty and lack of housing and that sort of thing.

So we are throwing an awful lot of good dollars after bad and not setting the area right. So, in my opinion, it is competing with more than just the space station. But, I understand the technical issue.

Mr. **Watkins**. UDAGs have been cut out. CDBGs have been cut a great deal. So those programs are gone by the wayside because of the tough, hard choices.

In Agriculture and Rural Development, some of us are very interested in that, we've had a 74-percent decrease in rural development in the last 8 years at a time when we've got to try to rebuild rural America. We're going to keep the very fiber of that part of our life thriving or moving forward. We've got to do it. We've had 74-percent cuts.

Mr. BILIRAKIS. I think we're throwing dollars at problems and not solving the problems with the dollars. Maybe we'd better take a look at how we are doing it.

Mr. WATKINS. Just let me run this thing and it will be all right.

Mr. BILIRAKIS. Thank's, Mr. Chairman.

Mr. MONTGOMERY. Wes, we will, if you get us more money. You'd better not tell these other people on the Appropriations Committees because—as soon as we get into other areas over there—but you've been very helpful. I know other Members say you've been very helpful. We certainly will consider and take a look at that clinic.

Mr. WATKINS. This committee and the veterans of America have my support in this. You can rest assured I'll do everything I can, but we've got to try to provide more revenue if we can also.

Thank you.

Mr. MONTGOMERY. Thank you very much, Wes.

Before recognizing the chairman of the Subcommittee on Compensation and Pensions, I believe I'll have the first panel move up to the witness table.

Dr. Kenneth Shine and Dr. Bowles will be on panel one. Then we'll get panel two and panel three.

The Chair recognizes Doug Applegate.

Mr. APPLEGATE. Thank you very much, Mr. Chairman.

I've reviewed, along with my staff, the testimony of today's witnesses with great interest. There is an obvious consensus that the budget request falls short of providing the Veterans' Administration with the necessary resources to even maintain its current level of health care and benefits delivery to our Nation's veterans.

Once again, the budget request has failed to recognize the perilous position that the Veterans' Administration is in today.

No one can argue that the greatest single area of concern at this moment is the shortfall in the VA health care budget.

Running a close second, however, is the ever-increasing deficiency in the benefits delivery system. I noted on Tuesday that the budget had attempted to protect, at least to some degree, the level of staffing in the adjudication division of the Department of Veterans' Affairs.

Nonetheless, once again, a reduction in staffing was requested. This has been unacceptable to the committee in the past and is still unacceptable today. There is a direct relationship between the level of staffing and the ability to process veterans' claims on a timely and accurate basis.

Even the budget recognized that there could be no improvement in the adjudication of the claims unless the proper resources and staffing levels were provided.

I plan to do everything I can to see that that's accomplished.

Finally, although I missed the presentation on Tuesday of the Independent Budget submitted by the DAV, the VFW and the AmVets, I do want to acknowledge their fine efforts in preparing a very thorough, very realistic budget which will be extremely useful to the committee in formulating its final budget recommendations later this month.

Of course, of particular interest to my committee, they seek to restore employees and funds to a level that will help to enhance timeliness.

But, all of this is for naught unless, as the Chairman has stated already, if the veterans' organizations themselves do not march to the same tune, and if they don't utilize the strength that they have and the power that they have with the Budget and the Appropriations Committee, it's just not going to work.

I think we got the message across to Wes Watkins, but Wes is only one individual and he has committed himself to helping us. But he is a realist, too, and the monies are there but they have to be competed for.

And I think, with the strength of the veterans, with 80 million people dependent upon the Veterans' Administration, which is one-third of the Nation's population, we ought to have power, be able to go into the Budget and Appropriations Committee and to get the monies that are necessary to take care of those veterans and their dependents and their survivors.

Thank you very much, Mr. Chairman, for the time.

Mr. MONTGOMERY. Thank you very much.

Let the Chair make a couple of announcements before introducing our witnesses here today.

As you recall, we are in recess but the DAV requested that they move ahead with their hearing that we have every year with the different veterans' organizations, and that's on February 14th. If you can come back to this joint hearing with the United States Senate Veterans' Affairs Committee, it will be on February the 14th and we will take care of the transportation.

Now, the next meeting after February 14—and we won't be calling the roll or anything on that day—February the 22nd, we will have a full committee markup of the Budget. You know, we've been going rather slow around here, but I want to thank the Members here.

We probably were the first committee organized, the subcommittees organized yesterday. I was on one of those committees and we're about half through with our full committee meetings.

I thought Members would like to know that.

The Subcommittees will be meeting, but we've got a good start and I would certainly like to keep it up.

On February 22, again, when we will be back, we plan to take an official committee photo of all the committee Members and it makes a good picture. It's a good setting. And I hope that the Members will try to be here on February 22.

For the full committee Budget Markup, we have to have those budget recommendations into the Budget Committee, and then we would also like to take a picture.

About 9:45, Bob Stump and I will be going to Congressman Frank Horton's office, who is ranking minority member on the Government Operations Committee, which was the committee of jurisdiction for establishing the Cabinet position for the Veterans' Administration.

We will give him what is called a red line bill that was signed by the President, by the President of the Senate, and by Speaker Wright. It's nice that it will be coming from the full committee because we would not have gotten Cabinet level status if it hadn't been for Government Operations.

And at 11:30, if any Texans or others want to go to Jack Brooks' office, we will also give Jack Brooks a red line.

I thought Members would like to know that and they're invited to go to any two of these presentations.

Panel one, Dr. Shine, is an associate with the American Medical Colleges. He's with the Friends of VA Medical Care and Dean of the University of California, Los Angeles School of Medicine.

Dr. Shine, you've been here before, and we appreciate your coming back.

Dr. Bowles, the Special Medical Advisory Group, Veterans' Administration, Vice-President for Medical Affairs and Executive Dean of George Washington University School of Medicine and Health Sciences.

Thank you, gentlemen.

Dr. Shine, the full statement will be put in the record for both of you distinguished medical professors, and we thank you for being here.

STATEMENT OF DR. KENNETH I. SHINE, M.D. ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH, DEAN, UNIVERSITY OF CALIFORNIA, LOS ANGELES, SCHOOL OF MEDICINE

Dr. SHINE. Thank you, sir, for having us with you this morning. I'm Dean of the UCLA School of Medicine in Los Angeles, with three important VA facility affiliations, one of America's outstanding psychiatric facilities at Brentwood, the Sepulveda VA Medical Center, which, among other things, pioneered in multi-disciplinary care of geriatric patients and demonstrated not only that a program in multi-disciplinary care could improve care for the elderly veteran but could do it for less money; and the Wadsworth VA Medical Center, which is a flagship program with a substantial age component.

I represent the Association of American Medical Colleges with its 127 medical schools, 88 academic societies, 435 teaching hospitals of whom 70 are major VA facilities, and the Friends of the VA.

And, Mr. Chairman, we would like to submit a list of the members of the Friends of the VA for the record.

Mr. MONTGOMERY. Without objection.

[The information appears on p. 388.]

Dr. SHINE. I'm a teacher, a cardiologist, and a consultant but one of the interesting parts of my career is I had the privilege to serve as cardiologist to the late General Omar Bradley.

In the context of my knowing General Bradley, he told me on several occasions the most important contribution he made as Administrator of the Veterans' Administration after the Second World War was the decision to affiliate America's VA hospitals with America's medical schools. And his vision was clearly vindicated in terms of the high quality of faculty, physicians, house staff, the role of students in those facilities.

It is my deep concern that those affiliations are in serious jeopardy and that unless something is done significantly within the next several years, we will see erosion, if not destruction, of a number of those affiliations.

The current level of funding for the current VA operating budget has had an extraordinarily negative effect on the morale of faculty, on the number of physicians that could be recruited upon the support staff, including nursing.

The fact that the capital budget has been cannibalized in order to put money into the operating budget has meant that radiology equipment, other kinds of equipment is old and has increasing difficulty with maintenance of service.

It is very difficult to get engineering supply service and a variety of other functions to work well in this VA facility, this at a time when there must be a major increase in the amount of ambulatory services provided to veterans where facilities for ambulatory services must be renovated and new kinds of configurations of staff developed.

What is most important to me is that the ability to recruit young people to VA positions as career physicians is progressively being eroded. Let me give you one or two examples from our own experience.

The failure to have state-of-the-art radiology equipment at the Wadsworth VA Medical Center has meant that we have been unable to recruit a Chief of Radiology Services at that facility. That in turn has limited our ability to recruit other physicians, and that in turn now jeopardizes the residency program between the University Medical Center and the VA, such that this spring we anticipate the residency review committees will tell us that we cannot include the VA rotation in that residency rotation.

We are currently having difficulty recruiting Chiefs of Rheumatology at Wadsworth, a Chief of Psychiatry at Brentwood. A very distinguished Chief of the Medical Service at Sepulveda is about to step down, frustrated and angry that although that facility responded to the RAM model in such a way that they would be RAM winners, that not only were the winnings taken away but in fact their budget was further cut.

If you think this is a problem located only on the West Coast, let me just for a moment quote from a statement written by the distinguished Dean of the Yale Medical School in October. Dean Rosenberg says:

"The training of Yale's medical students and residents must take place only in quality institutions which can serve as a model for our future physicians. However, the lack of sufficient financial support has eroded the quality of patient care at the Westhaven VA Medical Center. These two statements describe an impending crisis which, at its worst, could force a serious reevaluation of our medical schools' relationship with the VA, a prospect which both frightens and saddens me."

We strongly support the recommendation for a $12.42 billion medical care budget. We believe it is particularly important that the research budget be raised to $249 billion.

I would remind you that that research budget, which is a very high leveraged budget, is one of the most important factors in encouraging young people to come to the VA, and with all of these other things going on, it is clear that the lack of adequate research support is another disincentive.

In our region all of the medical schools are acting conjointly to improve the ambulatory care program, with strong support from the Regional Director, Mr. Lindsay. We have found ways to combine NIH and private money to strengthen programs at those facilities, including placing endowed chairs in a VA hospital and building other facilities with private donations.

But most important, we must be able to recruit outstanding people. We believe that the veterans' facilities are a national resource, providing care for some of our most deserving citizens, our veterans.

In my own personal case, it is my fervent plea that Omar Bradley's vision not be blurred further and not be destroyed, and what I am trying to suggest is the general perception of deans around this country, that we are in imminent danger of doing just that.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Shine appears on p. 389.]

Dr. **ROWLAND OF GEORGIA** [presiding]. Thank you very much, Dr. Shine.

Dr. Bowles.

STATEMENT OF DR. L. THOMPSON BOWLES, M.D., SPECIAL MEDICAL ADVISORY GROUP, VETERANS' ADMINISTRATION, VICE PRESIDENT FOR MEDICAL AFFAIRS AND EXECUTIVE DEAN, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCE

Dr. **BOWLES**. Dr. Rowland, Members of the committee, and staff, my name is Tom Bowles, Vice President for Medical Affairs at George Washington University Medical Center, a member of the Veterans' Administration's Special Medical Advisory Group.

It has also been my privilege to serve as a consulting thoracic surgeon to the Washington VA Hospital, the Martinsburg Veterans Hospital for over a decade.

The Special Medical Advisory Group is concerned about the President's budget proposal for 1990. With the initiatives enacted in 1988, there is insufficient support for current programs.

The passage of Public Law 100-322, the Veterans Benefits and Services Act of 1988, requires significant added effort, a pay increase from 2 to 4 percent, increasing requirements for special salary rights, increasing demand for services by AIDS victims in the veterans population, and a Federal employee health benefit increase. All impose considerable pressure on the current budget.

The 1990 budget proposal does not support these increased demands.

Current employment in the Department of Medicine and Surgery is 191,800. This number is 3,000 less than the Congressional requirement, without a 1989 supplement further reduction to a level of 186,000. By moving funds from other accounts the Department of Medicine and Surgery has been able to remain near the Congressionally mandated 194,720 employment level. Only action by the Congress can provide a 1989 supplemental appropriation which will preserve the medical capability of the Department, a capability which you and your Congressional colleagues have determined must be provided for veterans health care.

VA hospitals all over this Nation have been delaying necessary construction, renovation, and technology installation in order to maintain personnel at necessary levels. Unless this situation is recognized and addressed by the Congress, the patient care environment cannot be adequately sustained.

Nursing personnel, medical and X-ray technicians, and other technical staff are in short supply all over the United States. Without increases in salary support, a growing number of VA medical centers will not recruit and retain adequate staff in these critical areas.

The same is true of physicians. Without major increases, the dedicated medical personnel in the system are less able to sustain their families on their income supplied by the VA system.

If the President and the Congress wish to honor current commitments to veterans, the 1990 budget must be increased to at least $12 billion. This level would support a balanced program involving the mandated number of 194,720 full-time employees.

Without such an increase, the Congress should, in my opinion, reexamine the legal commitments to care which are currently on the statutes. Either programs or eligibility for care must be constrained or cut.

It is SMAG's position that the country is obligated to provide its veterans with the services described in our current laws and, as such, should provide the additional 1.3 billion over the President's 1990 budget proposal.

It has been my privilege to serve as a surgical consultant to veterans hospitals during the past decade. The competence and dedication of the staff members at these institutions has been in every way exemplary. However, I do not believe these institutions can continually manipulate their capital budgets to offset inadequate support for services. If the Congress legislates an increase in services, it must provide the programmatic support for these initiatives.

Mr. Chairman, thank you for the privilege of addressing you this morning.

[The prepared statement of Dr. Bowles appears on p. 393.]

Dr. ROWLAND OF GEORGIA. Thank you very much, Dr. Bowles. Thank both of you for the very strong and revealing statement, reinforcing what we have already heard repeatedly.

As I understand it, listening to you, Dr. Shine, the residency programs are in great jeopardy in Veterans' Administration hospitals in the regions all up and down the West Coast, from which you come, and the reason is because of the deterioration of infrastructure. You mentioned X-ray equipment and also air conditioning equipment, all kinds of equipment that is needed to keep hospitals going.

Let me ask you of this, the significance of the loss of those residency programs, what percentage of the residency programs in the United States are in the Veterans' Administration?

Dr. SHINE. Some 12 percent of all the interns and residents in the United States are trained in Veterans' Administration facilities. So it is a very substantial portion.

Dr. **Rowland of Georgia**. If we lost those residency programs, what would it do to the overall health care delivery system in our country, in your opinion?

Dr. **Shine**. It certainly would have a detrimental effect, but I think the more important issue is that a very substantial amount of care to veterans comes from those residents and, indeed, because of the differences in the salaries of residents as opposed to the salaries of full-time physicians there is a substantial economic benefit derived from the provision of well-supervised, high quality care by residents within the VA facilities.

So the erosion of those programs would substantially increase the availability of the physician around the clock or the availability of physicians to do many activities and would require the employment of an increasing number of staff physicians or other kinds of physicians to provide that care.

Historically, before the Bradley era, that often resulted in the employment of what amounted to a second class quality physician cadre, using residents who are there as part of their training. You have an opportunity to get a very high quality individual who may be training but who is well-supervised and is consuming a very substantial amount of service.

Dr. **Rowland of Georgia**. Your answer leads me to another question, and this was in the line of discussion that we had the day before yesterday here that a comparison between the medical care delivery in the VA and Medicare and Medicaid, that if in fact the VA was not available to deliver the care to these people they would go to facilities where they would get their care under Medicare and Medicaid.

In conversation with you earlier, you talked about the shift of people from the county to the VA and back, depending on just what the situation happens to be at any particular time.

My question is to you—let me make a statement and ask you if this might not be true, that medical care generally may be delivered more economically in the VA than it is under the Medicare and Medicaid system. We are looking now for some comparisons, and I would like to have your thoughts on those comparisons, and if in fact that does turn out to be true, would it not follow that if Veterans' Administration facilities were not able to deliver the care it actually may cost the government more in the long run to have to provide the care in the Medicare and Medicaid systems?

Dr. **Shine**. I think there are two parts to this. We are very much involved in this because we are involved with two county hospitals, which are teaching hospitals, in addition to the VA. I have made the following observations in this regard.

First, the overall funding of indigent care and the uninsured is inadequate. Under those circumstances any patient who is turned away from a VA hospitals is subjected to potentially defined care, in the State of California, for example, at one of the county facilities. Those facilities are already understaffed, overburdened, can't provide outpatient prescriptions, and so forth.

So the veteran under those circumstances is pushed into a situation in which the care in fact is probably not comparable to that in a veterans facility and, as a result, the worse the care gets in the county systems the greater the pressure on the VA facilities to try to deal with the veteran who there finds also resources limited.

So that the fundamental problem for the veteran or for any underserved population is the fact that there aren't appropriate alternatives in terms of obtaining care.

The facts are that if you look at what has happened in the VA, there has been a dramatic decrease in length of stay. The use of the plant has become much more efficient. The use of the ambulatory arena has become much more efficient, and I believe substantial amounts of money can be saved if that ambulatory arena is used in a very productive way and can be very cost effective. But that requires a reorientation of priorities and also requires some investment in the infrastructure required to give the ambulatory care.

Dr. ROWLAND OF GEORGIA. Dr. Bowles, would you respond, also?

Dr. BOWLES. I would just affirm what Dr. Shine has said, sir, and I believe that really cuts in Medicaid have been encountered all around the country, certainly in this area, and are forcing a greater number of veterans who might otherwise have sought care through the Medicaid system into the VA system.

I don't see any chance that that is going to decrease in the coming years. It is inevitable both in the outpatient and inpatient areas the demands for service are going to increase. At the present time these hospitals and their outpatient clinics are poorly positioned to cope with that increase in demand for services.

Dr. ROWLAND OF GEORGIA. My time is out, but I do want to ask one more question to follow up on what I asked.

Do you have any thoughts about whether or not service in the VA quality care can be delivered more cost effectively than it is under the Medicare and Medicaid program, realizing that we have less than $11 billion to treat a given amount of veterans, and if you look at what Medicare and Medicaid is costing on the Federal level, it is over $130 billion for this fiscal year.

Could you comment on that?

Dr. BOWLES. I can try, sir, with one response. It would be difficult for me to make a valid comparison in the cost effectiveness of the two systems because there is such variability throughout the country in the way these dollars are used and accounted for.

I do think when they are properly supported the care provided in the veterans system at least is equal to the care provided in the Medicare and Medicaid programs, and I don't see why there is any reason that it would not be provided just as efficiently.

Dr. ROWLAND OF GEORGIA. Thank you.

Mr. Penny.

Mr. PENNY. I don't have any questions.

Dr. ROWLAND OF GEORGIA. Mr. James.

Mr. JAMES. To follow up on that same question, where would we look to find a fair comparison with the civilian version of the DRGs and local hospitals to compare the services rendered so we could use as a sales point, if you will, the value of the veterans hospitals, the tax burden and load that it will take off the general population?

If, for example, the same procedure—and you have got the procedures set out, as you are aware, in all hospitals throughout the

United States, DRGs for different procedures—could you make a study of that because it may well be that if, for example, you provided no veterans services at all that actually costs us money?

If that is the case, we need to know it at the earliest point in time because medical care costs are going up astronomically in the civilian sector, over 20 percent a year.

So what would be a quick way to get into that information?

Dr. **Shine**. That is an important question. One of the items in the research budget is an item for some increased funding in health services research. At least at our own institution we have some very good people who if properly funded could try to get at that question.

It turns out that just making comparisons without risk adjustment is very, very tricky. The veteran is commonly, particularly the elderly veteran, is a very complex patient with a lot of problems, which make it almost impossible to extrapolate from a particular disease entity inside and outside the veterans.

So this is one of the reasons we believe that maintaining the research budget and particularly encouraging the health services research component of that would be very constructive in terms of getting the answer to your question.

Mr. **James**. You may not be able to do it very scientifically because of the variances, but nevertheless you are dealing with the gross numbers of the population that are served through veterans facilities, the number of hospital days they receive. You could do it through a computer?

Dr. **Shine**. As long as one recognizes that you have got to adjust. For example, just the difference in the incidence of cigarette smoking in veterans compared to the nonveteran population makes a substantial difference in comorbidity and the ability to deal with a variety of issues.

So I think it is a very useful approach. It is a little like looking at Medicare data when Medicare publishes their own mortality and morbidity data. They demonstrated recently some of it is meaningless because the patient populations are different.

I think the VA facilities in general are treating a sicker, more complex patient than Encino Hospital in the San Fernando Valley.

Mr. **James**. By the same token, the VA patient also goes to civilian hospitals and they have records on ones that are also eligible for VA, and you could make a comparison veteran to veteran, some kind of statistical data. Can we sell the product or not as far as taking the tax burden off or at least not increasing it if our facilities are improved or increased?

Dr. **Shine**. Again, one needs to be careful because the veteran who has an income level high enough so that he has insurance or other options, who goes to the civilian hospital, is in general a less sick veteran, and in fact what commonly happens is when the veteran goes through, loses his job, or goes through his health insurance, then he shows up at the VA facility. At that point he is much more likely again to be much sicker.

So again I am not arguing that one ought not to try to look at those kinds of things.

Mr. **James**. Perhaps you could compare the patient days as the civilian hospitals do, detailed data on patient days, facilities, et cetera, and then you can compare the procedures and tell us something we can sell.

Dr. BOWLES. To the extent that one can match the patient populations, I think a study of that sort would be very helpful and it might yield some interesting results. But I share Dr. Shine's concern with matching these patient populations. They are different, and that needs to be kept in mind when comparisons are made.

Mr. JAMES. I understand there are socioeconomic deviations between the two. The economically better off would be more likely to take care of themselves, et cetera. But that is why I am saying we ought to get data on patient days, specific procedures—thoracic procedures, for example, in your case or other procedures, that the Government has gotten down to that as far as for Medicare and Medicaid. Whether legitimately or not, they use that technique. They already have it pretty well refined for specific procedures.

So I was wondering if you could make that comparison.

Thank you.

Dr. ROWLAND OF GEORGIA. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I want to thank both the doctors for their testimony and ask them if they have had a chance to see the new supplemental appropriation presented by the Secretary Designate.

Have you had a chance to see that?

Dr. SHINE. No.

Mr. EVANS. We had a little preview of that on Tuesday at our hearing earlier, and while we do appreciate that he is not even confirmed, there are in the request—which, by the way, has not necessarily been approved as of yet but has been recommended to OMB at least—there is no provision for dealing with the 1 percent productivity cuts.

I wonder how you would react, given your testimony that since 1980 the VA workload has increased by 60,000 patient treatments, 5 million outpatient visits, and 38,000 nursing home stays.

Due to a productivity cut, given the fact that this looks like you would have an increase in productivity in the VA without any real increase in real dollars spent, do you view that as a penalty?

Dr. SHINE. I view it as kind of silly, frankly. The fact of the matter is that not only has the load been increasing, but the amount of faculty time and attention being paid to patients, in my view, has increased very significantly over the last 6 or 7 years.

At least in our institutions we have paid increasing attention to not only the care that the residents are giving to this larger number of individuals, but also to the quality of that care and to their supervision, and it just bears no relationship, it seems to me, to what is the real world in terms of productivity.

Dr. BOWLES. I would agree with that and simply say that I think the 1 percent productivity cut may well be an important gesture within the broad scope of problems that you gentlemen face, but it is by no means any solution to the problem of increasing demand for services, and you are mandating that the Veterans' Administration hospitals provide those services while support continues to decrease.

Mr. EVANS. You know, I sometimes feel that we have statistics presented to us in this body; for example, on AIDS research. We are told while the overall medical research budget in the VA will be cut next year, that there will actually be increases in funding for AIDS research.

I think that makes us feel good, but then we find out that not included in the supplemental appropriation request also is money for AIDS training, mostly among, I understand, the personnel themselves that administer the care.

So on the one hand, we are doing something better in an area that is obviously going to plague the VA and the rest of the health care system for the immediate future at least and the foreseeable future, and then we are not funding the actual professional training in dealing with that problem that is presently occurring within the Veterans' Administration.

That is at least one problem I see. That is why we appreciate your coming forward to testify. I don't know if you have any comment about that.

Dr. SHINE. It is very hard to convey in a personal way the impact that I watched this last fall on six or seven truly distinguished VA faculty member scientists who in the first round of the VA merit review after in one case 24 years of funding was told his grant was not going to be funded, who was told that he was going to have to dismantle his program.

Now, it turned out that after months and months of juggling, and so forth, they managed to squeeze his grants among the funding levels. But if you were a young, bright physician interested in working in the VA system and I was trying to convince you that we really need someone to take on and take care of joint problems for veterans at Wadsworth and you could have a wonderful career and you can apply under the Merit Review System for a grant to get you going, and so forth, and that individual walks in and the first three people he interviews tell him the disaster that has taken place under the Merit Review System, what do you think the probability is that you would go there as opposed to go across to the university hospital where someone will give him a guaranteed grant or something of this sort?

The effect is just disastrous. What I am concerned about more than anything else is that there is beginning to be around the country a wringing of hands, an attitude of pessimism which has extended far beyond what the dollars look like.

I fully accept the responsibility to try to develop the dollar arguments with regard to cost effectiveness, but I really would like to communicate to the committee the intensity of the anxiety, fear, and unhappiness among physicians, aside from any issues of salary, which I believe will haunt us, and once that slide really begins to take place it takes a generation to recover from it.

The VA goes from being an outstanding place to work to a place where you don't want to go.

Mr. EVANS. We thank you for your testimony.

Dr. ROWLAND OF GEORGIA. Mr. Chairman?

Mr. MONTGOMERY. Thank you, Mr. Chairman. I had two questions, one for Dr. Shine and one for Dr. Bowles.

Dr. Shine, I feel when you made your statement about the slowing down of spending, in effect not enough money to run the VA hospitals, would you elaborate more on how that affects our agreements with the university medical training centers that we are very proud of? We couldn't make it without you and the VA facilities. How would that slow down the funding?

It has caused some problems between this agreement.

Dr. SHINE. Item one, at Wadsworth VA Medical Centers, we have one of the four centers for ulcer research in the United States, the so-called Center for Ulcer Research and Education, a VA-funded activity. That activity is in jeopardy in terms of its NIH funding because we have not been able to get the air conditioning fixed, renovations done in any kind of a timely way, and as a consequence, we are losing people working in there and now potentially losing the NIH grant.

The NIH grant funds people. 85 percent of that money is people, and as a consequence, there is a real concern on the part of our faculty as to whether that part of the research activity is really viable.

We have programs with regard to alcohol and alcohol research in which equipment has been required, and in those situations the lack of that equipment is likely to cost us the programs and the people.

I keep coming back to radiology, primarily because it is such a clinically relevant area, the radiology capital expenditure money that is used for the operating budget. Our Regional Director, Mr. Lindsay, has valiantly tried to scrape up a few dollars to modernize the radiology, but if the radiology equipment cannot be modernized, we cannot get a Chief of Radiology. Without the Chief of Radiology, we cannot recruit faculty. Without the faculty the residency program is in jeopardy, and we will lose the accredited residency program.

We will then not be able to rotate students because we will have neither faculty nor students, and what is most important of all, and I think what is most on the mind of this committee, the care of the patients at that facility will be jeopardized because unless we can deliver first class radiographic care it doesn't matter. We could have the best surgeon in the world, but if he doesn't get X-rays that he is really relying on and can trust, we are going to have a serious problem.

As I suggested, Lee Rosenberg, I can tell you—umpty-ump other deans will tell you the same story—they are concerned about sending their students into those environments; that is, where the support facilities are inadequate, where the ancillaries—where you can't get a turn-around on laboratory data in a meaningful way. That is not the kind of role model situation in which you want a medical student.

And so quality is not an average value. You can't just say you are good in some things and you are bad in some things, and you end up at an average value. If we let certain portions of the operation go, the whole thing ultimately will come down as far as I am concerned in an educational way.

Mr. MONTGOMERY. Thank you.

Surveys that we made by the VA committee staffs going out around the country bear absolutely on what you said.

Dr. Bowles, you can add before my time runs out also about research. How is that working?

We are proud of our medical research in the VA, working the medical schools.

Could you comment further about that? Dr. Shine did cover some of the problems of research, about not having enough funding, but we would like to have for the record your feelings.

Dr. BOWLES. Yes, sir. On behalf of the SMAG, I would just reaffirm the concerns expressed by Dr. Shine and perhaps underscore them further, in saying that without support for research activity it is predictable that the best minds and the capable people are going to be unwilling to commit their careers to the Veterans' Administration, Department of Medicine and Surgery. It is essential that the young, bright people coming into that phase of their careers have the opportunity to do research or they are going to be unwilling to work in that system.

Those young people who have worked in the veterans system have had an enormous impact on the quality of care that is provided over the years. Without those people it is predictable, I think absolutely, that within a decade, sooner in fact, you will find that the kind of doctors you are attracting into the system will deteriorate and the quality of care provided will suffer.

Dr. SHINE. I would just comment, sir, that the accomplishments have been extraordinary. I mean, if you look at our own institution, for example—I don't know how many people in this room use Cimetidine or one of the antacids related to it. That was basically developed in terms of its clinical application at the Wadsworth VA Medical Center and the Center for Ulcer Research. There are innumerable examples of outstanding research accomplishments.

I mentioned the geriatrics area. The first successful study of a geriatrics assessment unit and the idea that you could get cost effective care if you put elderly patients together and gave them a multi-disciplinary approach, that was a VA project and it was a landmark project.

Some of the very best work on cardiac drugs used in the treatment of arrhythmias, specifically the drug Amyotirone, was done at our Wadsworth VA Medical Center.

But I could go on and on. The fact that Gradioto got a Nobel Prize is something that has not escaped investigators working in the VA.

The prosthetics. The prosthetics research done in the VA in terms of ways of dealing with joints was not only outstanding for war injuries, but in our school we have one of the outstanding programs in what is called lymph salvage. In the earlier days when you had cancers in your arm or leg the only treatment was to amputate it. Today the lymph salvage orthopedists can remove the tumor, take out the knee, put in an artificial knee. So you end up with all the tumor removed.

That is a direct extension of the kinds of things that have come out of that kind of research.

At Sepulveda VA Medical Center we have individuals who have developed antibodies against myeloma cancer, and we are getting good results treating myeloma with antibodies.

I think you all ought to take great, great pride in what a relatively small amount of money in the VA research budget does, keeping in mind that you get about a five-fold multiplier effect.

When you appropriate $240 million, for example, you are buying well over a billion dollars worth of research if you are the NIH, and that is because you don't have all the indirect costs associated with it. It is because you don't have all the salaries that go with it because they are in the VA. It is a tremendous investment.

Mr. MONTGOMERY. Dr. Shine, you said it better than any of us have tried to say it over the years. We have seen the things that the VA medical research has done, and we really haven't basically gotten the story out. There's probably better stories.

What we are learning in the VA and the university medical centers, working together, goes out to the general public. It helps others, that we would like to show not only the veterans but it reaches out in all areas of the land.

Dr. SHINE. We have also arranged for private donors to work with us to build facilities on the VA property. That has also gotten us some public relations advantages because we can now talk about the Johnson site, the John and Ethel Wadsworth VA Medical Center, because I agree with you, we not only want the private contributor but we also want the recognition in the community of the great work that is being done.

Mr. MONTGOMERY. My time is certainly up, but let me make this point.

On research you are tied in with the VA research. Besides the patient treatment care, the university—I want this for the record if I am right—the university agreement between our medical schools and the VA does cover pretty well the research, and you are involved in these projects that we are talking about today?

Dr. BOWLES. Absolutely. The faculty research activities are being conducted in the VA hospitals. That is a very important component of the affiliations which I think we all agree are critical to the quality care provided for the veteran, and I just emphasize again what Dr. Shine said.

I think this research is beneficial to veterans all over the country, but also it is beneficial to the entire country and all the citizens who derive enormous benefits in their care from the research that is conducted in the VA system.

Dr. SHINE. Just to make it very clear, Dr. George Sachs, who is a world famous scientist, a senior medical investigator of the VA, and holds the Tiber endowed chair in the UCLA School of Medicine, he is located at Wadsworth, but he has got an endowed chair from the university and a research budget.

Dr. John Walsh is head of the Center for Ulcer Research and Education. We have just awarded him the Strauss chair, which is an endowed chair, the income from which he can use to support research at that facility.

So we are in it together, whether it is patient care, whether it is teaching, or whether it is research. We are in it together, and we want to stay in it together.

What I am trying to say and what scares the hell out of me is that I think the things that are happening right now are causing deans and departmental chairs to say we can't stay in, and we have already had one of our chairs pull out of an affiliated arrangement.

I am going to try to get him back in, but we are a university. I don't go out and run an army. I am a university. That means that I have got to convince him on academic grounds that he belongs there, and I think that is an important element in what we are talking about.

Mr. **Montgomery**. Thank you.

Dr. **Rowland of Georgia**. Thank you, Mr. Chairman.

Mr. Stump.

Mr. **Stump**. Thank you, Mr. Chairman.

Dr. Shine, could you comment on the proposal to cut DVA's research budget at the same time the NIH research budget is going to get an increase?

Dr. **Shine**. Again, sir, I think it is absurd. It makes absolutely no sense to me.

As I have tried to suggest, the VA research budget is one of the most economical cost effective research investments we can make. Only members of the VA who are at least 5A's in the VA can apply for those grants. They cannot put their own salaries on that grant. So when they get a research grant, it goes to do the research, not to pay their salary.

The NIH not only has to pay the salary of the investigator, but it also may have to pay in indirect costs anything up to—in some institutions you could get literally 100 percent of the direct costs and 100 percent more of indirect costs. Probably 70 percent is a more average value.

In the case of the VA, essentially all of that money goes directly to research. Very little of it is administrative. So you are buying high quality research at a relatively low price, which has had extraordinary productivity in terms of the contributions.

The whole business of being able to assay hormones in the blood to make the diagnosis of thyroid disease, to make the diagnosis of diabetes, that was VA research, and it makes absolutely no sense to be reducing the VA research budget.

Indeed, if you were going to say where could you put some money into research which was likely to have the greatest leverage, given that money is very short, the VA research budget is a spectacular place to do that.

Mr. **Stump**. Thank you.

Dr. **Rowland of Georgia**. Thank you very much.

Let me just ask you to do one thing, if you will, for us. You have mentioned some of the things on original research. Cimetidine you mentioned, prosthetic research, and I understand that the AIDS virus was discovered in San Francisco in the blood transfusions lab.

Isn't that true?

Dr. **Shine**. Yes. You have to be very careful. AIDS was first identified at the UCLA Medical Center by one of our interns. So I have to be very careful.

You are quite right. It was identified in blood in San Francisco, but my faculty, who were on that very first paper in the New England Journal, would never allow me to accept that San Francisco had priority.

But you are correct, sir, in the blood.

Dr. **Rowland of Georgia**. That was my point. I have to be very careful.

[Laughter.]

But could you both give me a list of things of original research that are done in the VA?

I believe there have been two Nobel Prize winners from the VA.

Dr. SHINE. That is correct. Yallow was one of those for her work in radioimmunoassay.

Dr. ROWLAND OF GEORGIA. The testimony this morning has been absolutely great.

Mr. Sangmeister.

Mr. SANGMEISTER. Thank you, Mr. Chairman. One question for a little background here.

As I understand the problem, it is not only losing present people that you have but also getting young doctors ready to come and do their residency to come to the veterans facilities, is that correct?

Dr. SHINE. Yes, sir.

Mr. SANGMEISTER. If I am coming out of the University of California or the University of Illinois and I am going to do my residency, what is the marketplace out there for me? Can I go anywhere I want because there is such a demand for young doctors and their residency?

The marketplace I guess is what I am asking.

Dr. BOWLES. The marketplace for graduates of medical schools is a tight one right now. In certain specialties there is a lot of competition for positions.

I am not sure what you are getting at with the question, but the veterans programs, by and large, are quite desirable because most of them are in affiliation or association with academic medical centers and it makes them attractive places to train.

Dr. SHINE. Perhaps I can respond in the following way.

The number of residency positions available in the United States is approaching the number of American graduates of American medical schools. What I mean by that is there are probably something in the range of 110 percent residency positions for the 100 percent of graduates of American medical schools.

So that on the one hand, you could say there will always be some doctors who, if they wanted the residencies, will want to go to a VA hospital because there is not a huge excess of unfilled residency positions. In fact, what is happening nationally is that a significant number of these residency positions are held by foreign medical graduates, and for a variety of reasons in public policy there is great pressure on the number of foreign medical graduates who are getting those residency programs, and by and large, a number of programs currently hiring foreign medical graduates are trying to shift to American medical graduates.

I just came back from site visiting Columbia in New York. The Harlem Hospital is an excellent example where Columbia is now making an increased effort to recruit graduates of American medical schools to be residents in those hospitals, and so what is happening is that the emphasis is increasingly a number of accredited programs in hospitals where there are largely foreign medical graduates in order to provide opportunities for Americans there.

So in the long run what will happen is if we don't have an adequate faculty, an adequate group of people in the VA's and those programs lose accreditation, they will not be able to take the residents, but those residents will now begin to move into the programs such as—Harlem Hospital is a very good example of that—and do their residencies there.

Right now the VA—at least until recently the VA has been more attractive. Therefore, you can get the very best residents under those circumstances, but that is beginning to change.

The average medical student is very shrewd. He knows or she knows what the on-call schedule is, what kind of support services there are, whether they are going to have to push the patient to X-ray or not, whether they are going to be able to get lab data in a reasonable way, and they make their decisions very much on the basis of things like that in addition to the quality of the faculty.

Mr. SANGMEISTER. I was not trying to imply, you know, if there is no place else to go there is always a veterans hospital, but I was wondering what the demand is out there.

What you are telling me is that there is actually an effort to recruit?

Dr. SHINE. Absolutely. There is a public policy issue here, which is beyond, I think, our specific concern today, but the public policy is the foreign medical graduates. The VA of course does not use the foreign medical graduate unless they have a certain level of visa, and one of the things which made the VA's difficult places to work before the Second World War was that in many places they weren't staffed by first class physicians and they allowed people on the margin.

That is no longer the case. One of the reasons is it has been so attractive to outstanding graduates of American medical schools.

Mr. SANGMEISTER. Just so I understand it right, the foreign medical student who is going to do his residency can do it in a VA hospital, but we don't make an effort to recruit that type of medical?

Dr. BOWLES. No, we don't, not in the VA system. The foreign medical graduate is eligible provided that graduate has passed the PCFMG examination and is eligible for training in an accredited postgraduate training program, including spots in the Veterans' Administration system.

I think it would be fair to say that by and large the VA system up to now has not particularly singled out those graduates for recruitment.

Mr. SANGMEISTER. Thank you.

Dr. ROWLAND OF GEORGIA. Mr. Ridge.

Mr. RIDGE. Thank you.

Doctors, I appreciate very much your testimony. I for one am pleased to learn that you believe that some of the best and brightest medical students are attracted to the VA health care system because of the research facilities that are available as attractive places to do residency, but I want to take it one step further.

Once you have attracted them and they have had the opportunity to do their residency and their research, are we doing a good enough job retaining them within the system, or do we lose them after they have done their residency?

Dr. SHINE. In our experience, the biggest single source of faculty, permanent physicians in our VA facilities have been the residents who have been trained there.

Now, you have to look at it in a couple of ways.

First of all, overall the percentage of students in a given class who stay in academic medicine is still relatively small. You are talking about anywhere from 6 to 20 percent, depending on the culture of the institution, and so forth.

In our experience, in fact, the proportion of our graduates, of our residents who have stayed in academic positions in the VA's has been very comparable to the proportion that have stayed in academic programs when they have done their internships at our university hospital.

Secondly, remember that in addition to the full-time faculty who are at those facilities we rely on voluntary faculty, clinical faculty to give care to a significant extent.

This is something that doesn't appear in your budget. This is the person who is trained at the Wadsworth VA Medical Center who went up to practice in Santa Monica, but every Wednesday afternoon comes back to supervise a clinic at Wadsworth. He does that because he wants to maintain his university clinical appointment. He is a clinical professor of medicine. To do that he has to give a certain service. In our system he has to have so many credits of education. That is donated time.

He can do that by giving that time at any of our teaching hospitals. If he was trained at Wadsworth or Sepulveda, he will go back to Wadsworth and Sepulveda and do his teaching there, and we are getting very substantial amounts of education and supervision on patient care by voluntary faculty who are graduates of those programs who, in the tradition of the profession, are teaching the people who come afterwards, and we don't pay them anything.

Now, in some cases some of those become consultants, and we do pay them something if they are also going to do a surgical procedure that we need special expertise in.

But I want to emphasize that in my Department of Medicine, for example, we have over a thousand clinical faculty graduates who are clinical faculty. About 20 percent of them do their clinical faculty instruction and service at one of our VA facilities, and that is a bonus.

Dr. BOWLES. Over the last two decades, many young products of residency programs who were interested in academic careers have found veterans hospitals, those affiliated with medical schools, attractive places to pursue those careers, and I think it has been to the benefit of the veterans population and all associated with those hospitals.

There is no question in my mind that over the last 2 or 3 years those young people are more and more frightened about approaching veterans hospitals for careers. I think we are seeing a lost opportunity develop here in large part because of funding constraints that were placed on those particular hospitals.

Mr. RIDGE. So I think to refer back to a comment you made earlier, Dr. Shine, you are talking about the whole health care delivery system. If you would identify the problem in one area, don't conclude that everything else can continue to function at the same level because decisions are going to be made because of the problems there, and you are indicating that your ability to retain these qualified men and women and you are personally concerned about it because they see the constraints on the system, the compression of services, the lack of dollars, and they are starting to look elsewhere?

Dr. **Bowles**. That is correct.

Dr. **Shine**. If you are going to take care—I am a cardiologist. I am taking care of sick patients who also happen to have been in an auto accident. I can take care of the myocardial rupture. I can take care of the aorta. But if I don't have an orthopedist to take care of the fractured leg, it doesn't do my patient much good. That is inadequate care. You can't do it.

Mr. **Ridge**. I would like to shift gears just briefly with my remaining time to talk about another area of health care. I can't be here for panel three, but I want to ask the doctors about the nurses.

You have identified, I think, in both your testimonies there is a shortage of nurses within the system. As I travel around Pennsylvania, our VA medical centers, the shortage is not only of nurses, but pharmacists, physical therapists. But I would like to focus in on nurses.

In Erie, Pennsylvania, a beautiful community in which I live, we have two very fine hospitals, and for the first time in years that I can remember I saw advertisements in the newspaper for registered nurses, surgical nurses, and the like.

I can't imagine us providing enough money in the VA budget to compete dollar for dollar with the private sector because it seems that financially we have finite resources and, although they don't have infinite, they just have a lot more to draw on than we do.

Would you just share with us your impressions generally about the impacts of the nursing shortage on the health care delivery within the VA and how it just generally has doctors looking at the whole system nationally, be it the VA system or private health care, and how we are going to get through the next several years with what I consider to be a very real crisis?

Dr. **Bowles**. It is a national crisis, as you have identified. It is also in the veterans system. There is no way to provide satisfactory and particularly excellent medical care without an excellent nursing staff. They are absolutely vital components of this medical care team.

The environment of the veterans system, the hospitals, as it has begun to deteriorate I think has had a harder and harder time retaining good nursing staff because it is becoming a less and less attractive place to work. It isn't purely a question of salaries, although clearly that is important, as it is for every human being, but if the environment itself begins to deteriorate and the nursing staff loses its flexibility in assigning its shifts and scheduling, they are going to find it harder and harder to both attract and retain nurses in that system. As the affiliations are jeopardized, I think it will become harder and harder to attract nurses and to retain them in that system.

There are a number of problems involved here. It isn't unique to the veterans system, but I think the problem is deteriorating more rapidly there than it is in the rest of the sector.

Dr. **Shine**. I don't think that one can ignore the financial portion of it. There is no question that unless salaries are in some way competitive with the outside world even the most dedicated individual under pressure is going to make the alternative.

I would point out two things. One, we do have a School of Nursing at UCLA, and we have just done for the first time through our hospitals—we have financed a doubling of the number of nursing students in that school, underwritten by the hospital, on the grounds that these nurses may go any place they want to nurse, but if we can increase the local pool there will be at least a few more nurses in that environment.

Secondly, please don't underestimate the advantage of a positive culture for a bright young man or woman who is interested in nursing.

If you have an exciting program—and I ran coronary care units for a number of years, and I had essentially no turnover, because if they are in a program where the faculty is excited, where the program looks like it is going well, the patients are getting good care and they feel good about it, people don't leave.

But if you look at a program in which you don't know when the next layoff is going to take place—if I was going to say there is one problem in the VA system which can't be solved without money, it would be to deal with the issue of predictability.

One of the biggest problems you have is the fact that every year you have this incredible unpredictability of what is going to happen. No matter how vigorous you are in supplemental or in solving the problems, until that happens everybody is in a state of panic, and the effect of that on people is disastrous, and if there were a mechanism, whether it is a 2-year funding cycle—you gentlemen know far more about these things than I, but I can tell you that I watch my people just go crazy. They know the VA has been spending in the first half as if they were going to get more money. They also know they may not get more money.

So how do you convince—the kinds of people we are talking about are not dummies, whether they are nurses or doctors or anyone else. They know what is happening. How do you convince them this is a stable place to work when every year you go through that, and I think if there was any way that this body could figure out how to smooth out some of the predictability—even if it was bad and you could plan for it, it would be far better than what we have been seeing.

Mr. Ridge. Thank you, Mr. Chairman.

I would just like to note the call for maybe a 2-year budget cycle would assure appropriations for planning and predictability purposes. We hear it elsewhere in the Veterans' Affairs Committee, and this is, hopefully, something that this Congress and the Veterans' Administration and other agencies would consider.

Thank you.

Dr. Rowland of Georgia. Certainly it would lend more stability to our last budget cycle, and I would hope we would adopt a 2-year budget cycle for fiscal year 1990–1991.

Dr. Shine, let me thank you for coming all the way across the country to be here this morning.

Dr. Bowles, I want to thank you and Dr. Shine for the amount of time you have given us here today. I know it's not easy to neglect your own responsibilities and come here, but your testimony has been excellent. It will help us a great deal in focusing more attention on this. And I hope it will get the attention of our colleagues in the Congress and the veterans groups to understand that they need to get actively involved too, as Mr. Chairman has already indicated earlier this morning, if we want to preserve this wonderful health care delivery system that we've got in the Veterans' Administration.

Mr. MONTGOMERY. Mr. Chairman, I would like to ask the two witnesses to help us publicizing these research projects. We have a problem sometimes in getting our witnesses' testimony out to the public. This has certainly been excellent. If our witnesses could help us, if there is a public information office here who we could contact to get your testimony out, it would be very, very helpful to the public to get it to publications around the country.

We would appreciate your helping us. We have Mr. Holly, who needs guidance, you know.

And the Los Angeles Times is not even here. I doubt if the Washington Post is here, and important things have been said. We just need some help.

Dr. BOWLES. You can count on our help in any way, sir.

Dr. SHINE. I also would point out that I think increasingly we have been meeting with the veterans groups at our facilities. I meet in the spring and fall on two occasions with them, and we are trying to build a dialog with the veterans groups so we both understand our mutual concerns and interests.

Mr. MONTGOMERY. I mean further the veterans organizations go out to the public, they see what we are trying to do in the VA facilities, working with your universities.

Dr. ROWLAND OF GEORGIA. Thank you again very much.

The next panel is: Mr. Samuel J. Walsh, assistant director, National Legislative Commission; Mr. John Sommer, of the National Veterans' Affairs and Rehabilitation Commission of the American Legion; Chuck Jackson, executive vice president of the NonCommissioned Officers Association; Mr. Thomas Sherwood, director of health policy and planning; Mr. Paul S. Egan, legislative director of Vietnam Veterans of America; Col. Herb Rosenbleeth, U.S. Army (Ret.), national legislative director of the Jewish War Veterans of the United States; and Comdr. John F. Wanamaker, U.S. Navy (Ret.), deputy director of legislative affairs for the Retired Officers Association.

Gentlemen, I thank all of you for being here this morning. I think we will take testimony from each one of you and then go to questions or comments that Members of the committee may have.

Mr. Walsh, if you will begin.

STATEMENT OF SAMUEL J. WALSH ASSISTANT DIRECTOR NATIONAL LEGISLATIVE COMMISSION; ACCOMPANIED BY: JOHN F. SOMMER DIRECTOR NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION THE AMERICAN LEGION

Mr. WALSH. Mr. Sommer will present our testimony.

Mr. SOMMER. Thank you, Mr. Chairman.

I will summarize very briefly our statement. In doing so, the American Legion will limit its remarks to two major areas of concern; that being medical care funding and staffing, and the projected personnel losses in the Department of Veterans Benefits.

We reported to this committee in September our concerns regarding inadequate funding and management problems that were facing the Department of Medicine and Surgery. I am sure that everyone in this room is aware that they have only gotten worse since that time.

Because of our concern, we have undertaken a survey of every VA medical center director wherein we are securing information on the impact of this funding shortfall and the staffing problems that they are encountering.

Preliminary review of our findings shows that over 80 percent of the medical centers have severely curtailed medical care to category B and C veterans and some nonservice-connected category A veterans.

This is only one of a large number of problems which have developed over the years and have come to a head just during the past several months, including the diversion of funds from supply, maintenance and new activation accounts, among others.

We will provide the committee with the results of our survey as soon as they are compiled and analyzed, which we anticipate will be in about a week.

The American Legion was extremely pleased to hear that Secretary-designate Derwinski had appealed to OMB for a supplemental of $314 million and 1539 FTEE for this fiscal year and an amendment to the FY 1990 proposal for an additional $512 million and over 5,000 medical employees as well as the additional $85 million for major medical facility construction.

This additional funding would go far in helping alleviate the existing problems, we are totally supportive of this move, and we will be voicing that support before the appropriate committees and the administration.

The other concern that we will touch on is the proposed reduction in FTEE in the department of veterans benefits of 550 employees. We have expressed our concern over the past several years about the effect that persistent personnel losses is having on the quality and timeliness of claims development and processing. The situation continues to deteriorate, as reflected in the figures on our full statement. We urge the committee to take a close look at this critical situation.

In closing, as all of you are aware there are some critical budgetary decisions that must be made if the VA, soon to become the Department of Veterans' Affairs, is to continue to adequately serve this Nation's veterans. We have faith in this committee, that it will play an important role in those decisions.

Thank you, Mr. Chairman.

[The prepared statement of the American Legion appears on p. 395.]

Dr. ROWLAND OF GEORGIA. Thank you, gentlemen.

Mr. Jackson?

STATEMENT OF C.R. (CHUCK) JACKSON EXECUTIVE VICE PRESIDENT NONCOMMISSIONED OFFICERS ASSOCIATION

Mr. JACKSON. Good morning, Mr. Chairman.

The NonCommissioned Officers Association appreciates the opportunity to comment on the FY 1990 budget of the Department of Veterans' Affairs.

We concur with the conclusion that many have stated before the committee: The budget proposed by the administration is a continuation of a shameful record of inadequate budgeting over the past 8 years which has resulted in the decimation of veterans programs.

The inadequate budgets since 1981 have resulted in veterans being required to pay for home loan guarantees, educational benefits, and medical care in many instances. Burial benefits have been terminated for most veterans, and cemeteries have been allowed to close without replacement.

Vietnam veterans will soon be losing the vocational rehabilitation payments as well as other educational benefits that have been allowed to fall severely behind inflation.

Mr. Chairman, this is a legacy of one of the most successful and popular Presidents in the Nation's history, and in no small part the cause of this dismal record must be shared by us all.

Veterans have been asked to do their share for deficit reduction, and we have done so. But now it is time to turn the table. It is time to once again recognize the contributions and needs of veterans and to respond to these needs as public obligation and public decency require.

In the area of medical care for veterans, we must resist reductions in personnel and oppose user fees for care. We must begin to address the $1.45 billion needed for modernization of aging facilities and the shortages in nursing and domicillary care beds.

Most of all, we must remove financial roadblocks to medical services from both the provider and the user standpoint. In the compensation arena, NCOA believes that we must ensure that adequate cost-of-living adjustments are made, but we must resist the indexing of benefits. We must continually review the adequacy of survivor benefits and to providing more reasonable DIC payments based on financial loss rather than military rank.

We must assure the continued value of educational benefits in both the new and old programs. NCOA still believes that participation fees must be eliminated, for they discriminate against the financially disadvantaged servicemember who might benefit the most from their use. We are hopeful that Mr. Bush, our education President, will have empathy with this particular program.

In the area of loan guarantees, we must continue to oppose the transfer of program costs to veteran participants by resisting quick fixes such as credit reform and without-recourse sales. We must seek innovative ways to recapitalize the loan guarantee program.

The Association has also recommended direct loan financing through Federally backed mortgage bonds, and the committee still has under consideration loan indemnification that was proposed last year. These ideas and others, Mr. Chairman, must be allowed to move forward.

In conclusion, Mr. Chairman, we must turn the tide toward addressing the problems of veterans. We must assume a role of solving these problems with reasonable budgetary response. We the veterans organizations and the Congress together must assume a greater role of leadership and responsibility in responding to the needs of veterans as we move towards the year 2000.

Thank you very much.

[The prepared statement of Mr. Jackson appears on p. 419.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Jackson.

Mr. Sherwood?

STATEMENT OF THOMAS SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING ACCOMPANIED BY PAUL S. EGAN, LEGISLATIVE DIRECTOR OF VIETNAM VETERANS OF AMERICA

Mr. SHERWOOD. Thank you for the opportunity for the Veterans of America to present its views on the fiscal year budget for 1990. We are saddened to witness the continued disintegration of veterans health care in the country. Where the need for additional dollars appears to be the solution, the fact remains that there are not enough dollars around to solve the VA health care system's problems.

VA has continued to stress that the ailing VA health care system, even within the protected ranks of the new Department of Veterans' Affairs, can no longer operate as a separate entity. The VA health care system is, in fact, interactively part of the larger health care system and very much effected by it.

The fact is, given the way the current VA health system is managed, operated, and oversighted, it will become more and more difficult for Americans to continue to pay for it in spite of the tremendous debt of gratitude owed to our veterans of all wars.

Regarding the VA health system, our fear should not be fear of mainstreaming, but the fear of isolation which will inevitably prove to far more costly than we could ever imagine or afford. The Independent Budget has correctly noted, the declining quality of care of veterans that they are now experiencing.

The Independent Budget has noted the demoralization of VA personnel who are trying to care for veterans in a sea of mixed messages. The Independent Budget has in fact noticed the apparent inability of the VA to simply deliver a good overall health care product.

Although we are unable to sign on regarding the Independent Budget because of its tendency to support same old centralizing organizational practices and, therefore, the status quo in the VA care delivery, we do appreciate its resounding acceptance and recognition of the limited quality of care veterans in this country are receiving.

What the VVA respectfully and sincerely requests of this committee and all interested parties is the recognition that it is no longer business as usual. The attitude of the VA health care system must change if we in fact intend to "care for him who has borne the battle and for his widow and his orphan," or if we intend in fact to "ensure quality medical care is provided on a timely basis to eligible veterans."

To this issue of change, we once again invite your attention to the recommendations offered under the legislative proposals that we have made. We believe that innovations such as the need for VACO to change its role from manager of health care to purchaser of health care in the name of veterans from the medical centers is essential.

Addressing the issues for change in decentralization, provider of choice, and direct accountability to the veterans through veterans governing boards can go a long way in effecting the necessary change the VA health care system will have to experience if it is to obtain the opportunity to improve the quality of care veterans must have.

We believe, in spite of resistance, that the VA health care system simply as a function of existing in the real world of a national health care crisis in this country will be forced to change.

This is simply a matter of time. Let us all climb aboard now, being proactive in this venture instead of reactive if for no other reason that we are not any longer willing to stand by passively, incapacitatively tied up in political knots while watching our veterans suffer at the hands of an antiquated health care system that cannot get out of its own way.

Once again, thanks for giving us the opportunity for us to address this issue.

[The prepared statement of Vietnam Veterans of America appears on p. 425.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Sherwood.

Mr. Rosenbleeth?

STATEMENT OF COL. HERB ROSENBLEETH, U.S. ARMY (RET.) NATIONAL LEGISLATIVE DIRECTOR JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Col. ROSENBLEETH. Mr. Chairman, I thank you for the opportunity to appear today to testify before this distinguished committee on behalf of our membership.

Since its founding in 1896, the Jewish War Veterans of the U.S.A. has stood for a strong national defense and for just recognition and compensation for our veterans.

I must open by commending Dr. Shine and Dr. Bowles. As I sat and listened to their testimony and the explanations that they gave of the health care system, it is really the best explanation I've ever heard, and I want to echo the words expressed by Dr. Shine and Dr. Bowles as I start out.

Mr. Chairman, the Jewish War Veterans members are responsible citizens who clearly understand the meaning of Federal budgetary deficits and who realize this Nation needs to find a solution to our national fiscal problems. As an organization, we have not in the past, nor will we in the future, ask the Congress for more than we think is fair and in the best interests of our Nation.

But even with this in mind, even with a statement like that, JWV finds both the present fiscal year 1989 and the proposed fiscal year 1990 VA budgets severely inadequate.

Of greatest concern to our organization is the inadequate funding of the VA health care system. I have used the figure in my written statement of some $650,000. This week's Congressional Quarterly cited something like a billion or more, I read yesterday. Whatever the number, it is a large number. And as Dr. Shine and Dr. Bowles pointed out, this kind of thing, once it already hits—and I think he used the words—it will take a generation to recover. This seems to me more than empty rhetoric.

JWV strongly opposes the view of Jim Miller, the recent Director of OMB, and members of his staff for stating that the veterans programs are low-priority services. We believe the veterans programs are high-priority services and are among the most important national priorities.

Three things that we specifically feel strongly about are opposing the increase from 2.8 percent to 3.8 percent in the origination fee charged for VA-guaranteed home loans. As you know, a house today is $100,000, $150,000, $200,000 in this area. $200,000 is a normal three-bedroom house. When you add 2.8 percent to the origination fee on top of the closing costs, you really sock the veteran pretty hard. And that includes the active military moving to this area who have left post housing and moved to Washington, D.C., under orders from the Government, and they cannot buy a home in this area.

We are strongly opposed to the repeal of the recently reinstated travel allowance eligibility to allow only veterans in need of special transportation for those who live over 100 miles from the VA medical facility to receive this benefit. Congress went to great lengths—the 100th Congress—to pass and reinstate the beneficiary travel allowance. We do not want to see that change.

Our third point that I have in the written testimony, one which Dr. Shine covered so well, was our opposition to reduction in medical and prosthetic research by $12.9 million as well as a cut in the number of full-time research employees by nearly 9,000, as proposed in the 1990 Reagan budget.

It seems to me that this type of backward planning on OMB's part, it seems what they do, they use the previous year's figures, first they reduce the staff and the reduction of the staff causes reduced workload; then the next year they say the workload is down. Therefore they can cut the staff more.

We want to express our opposition to this kind of thinking. I emphasize that the portion of the total Federal budget being used by veterans programs continues to decrease from 5.0 percent in fiscal 1975 to 3.3 percent in fiscal year 1982, down to less than 2.5 percent in this fiscal year. Any further reductions seem totally unacceptable.

The Jewish War Veterans officially endorse the concept of the Independent Budget prepared by VFW, Amvets, DAV, and PVA. This budget seek to assure that the VA will provide benefits and services in a cost-efficient, timely, and coherent manner.

The Jewish War Veterans of the U.S.A. appreciates being able to appear before this committee on this extremely important issue. We are grateful to the chairman and his entire committee for their efforts in supporting America's veterans.

[The prepared statement of Colonel Rosenbleeth appears on p. 443.]

Dr. **ROWLAND OF GEORGIA**. Thank you, Colonel Rosenbleeth.

Commander Wanamaker?

STATEMENT OF CMDR. JOHN WANAMAKER, U.S.N., (RET.), DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, RETIRED OFFICERS ASSOCIATION

Cdr. **Wanamaker**. Thank you, Mr. Chairman. I am Cmdr. John Wanamaker, U.S.N. (Ret.), deputy director of legislative affairs for the Retired Officers Association, which has its national headquarters at 201 North Washington Street in Alexandria, Virginia.

Our Association has a membership of more than 359,000 active-duty, retired, and reserve officers of the seven uniformed services. Included in our membership are approximately 50,000 auxiliary members who are survivors of former members.

Mr. Chairman, I plan to highlight my statement and to have the full statement included in the record.

In regard to the compensation programs, the 1990 budget request for the newly established Department of Veterans' Affairs seeks $318.1 million to fund the estimated 3.6 percent cost-of-living adjustment to the disability compensation and dependency and indemnity compensation programs.

Our Association strongly supports legislation that will maintain the level of benefits lost to inflation that will replace the lost income due to injuries or death which these programs are designed to provide.

I would call to the attention of the committee that the inflation rate of 3.6 percent may well be exceeded. It seems that estimate is more conservative than that provided by most estimates or even the most recent estimate of 4.9 percent from the Congressional Budget Office.

Our Association also urges the committee to include in their budget requests to the Budget Committee sufficient funding to correct the inequities that exist whereby military retirees who have served 20 or more years of military service must forfeit an equal amount of military retired pay in order to receive VA disability compensation.

Since this issue is a joint Armed Services and Veterans Affairs issue, I urge this committee to coordinate their budget committee submission with that of the Armed Services Committee.

The budget proposal, although calling for the 3.6 percent adjustment for the VA compensation, the waiver requirements of Public Law 85–857 effect this increase, the net result is no increase—in fact, a loss in purchasing power for those disabled veterans who are military retirees, since this same budget request and budget proposal before you calls for the elimination of the cost-of-living increase for Federal retirees in fiscal year 1990.

A similar situation exists when increases are made in the dependency and indemnity compensation program offset annuities provided by the military services benefit plan. I know these programs receive oversight in the Armed Services Committee, but since they apply to veterans too, I want to bring this to your attention.

Finally, almost every Federally administered survivor program, including Social Security, Civil Service survivorship programs, military survivors benefit plan, provide continued receipt of those benefits should the widow remarry after age 55. We urge the Members of this committee to look upon these widows receiving dependency and indemnity compensation in a kinder and gentler fashion and authorize the continuation of those benefits in a similar fashion.

In relation to the home loan initiation tax, legislation has been proposed to increase the 1-percent home loan initiation fee to 3.8 percent, effective October 1, 1989. I know in recent years the Congress has rejected a much less ambitious increase in that VA home loan initiation fee. And our Association would ask not only that you again reject that increase but allow the current 1-percent tax to be repealed.

During the next 5 years, should the base closure and realignment proposal be approved, during that 5-year period the plan calls for the movement of over 56,0000 military personnel, a high percentage of whom either currently hold VA mortgages on their homes or will need assistance of the VA Home Loan Program to re-establish themselves when moving to new locations.

This does not take into consideration the tremendous losses many will incur due to the necessity that they will be forced to sell their homes in a depressed market time-frame while at the same time purchasing the new homes in areas where the increase in home prices will reflect the increase in military population.

There must be a better way to raise taxes.

Much has been said by various groups that the VA medical program has been drastically underfunded. To determine the proper amount for this purpose is beyond the capabilities of our Association to make.

However, there are areas which we readily recognize need and require Congressional attention. With the passage of the Medicare Catastrophic Coverage Act of 1988 becoming effective on January 1 of this year, a situation has been created whereby veterans are being subjected to costs for their health care which exceeds that required by society in general. Many veterans in category C who are over age 65, eligible for Medicare, are subjected to multiple deductibles for care in VA hospitals. In the Medicare program they would be limited to a single deductible. There is no cross-transfer of credit of VA deductibles towards Medicare or vice versa.

In order to correct this problem, I would recommend:

One, eliminate the means test for category C beneficiaries over age 65; or

Two, exchange the deductible credits between VA and Medicare to limit the combined costs to the Medicare limitations; or

Three, make Medicare subject to reimbursement to the VA for care provided Medicare-eligible beneficiaries.

Our Association would recommend a combination of 2 or 3 because the majority consider that Medicare enjoys a free ride for those of the beneficiaries who are treated by the VA. And I don't have to tell Members of this committee the VA medical system needs the funding.

Mr. Chairman, one issue, new legislation and a new initiative not covered in the budget request. It has to do with the burial benefits for Medal of Honor winners.

It recently came to my attention that upon the death of a Medal of Honor recipient, that all of the immediate family were unable to attend because of financial difficulties. A bill that is now before your committee, H.R. 451, would provide these expenses similar to that provided POWs. I ask the committee's favorable consideration for that proposal.

[The prepared statement of Commander Wanamaker appears on p. 445.]

Dr. ROWLAND OF GEORGIA. Thank you for your testimony.

Mr. Sherwood, it is suggested that it is time we recognize it's not business as usual. We recognize it's not business as usual. We have known that for some time.

You heard this morning testimony about the great quality of care in Veterans' Administration hospitals, how good it is, from the research perspective. You have also heard about the threat now of the loss of this quality of care, about the impending deterioration and loss of this system if something doesn't take place. The two physicians we had and Wes Watkins, who served on the Appropriations Committee.

But let me ask you this. What ideas do your organizations have to spread the word about how good these programs are and about the threat that is now posed? What are you doing to let your membership know the situation as it actually exists and how much do your members know about the situation that exists?

Mr. SOMMER. Mr. Chairman, speaking for the American Legion, I can tell you we in the veterans affairs and rehabilitation area contribute regularly to our magazine which goes out to over 3 million individuals throughout the country, as well as the two publications that go out from our public relations division, both of which go out to every post in the country—there are about 16,000—as well as individual news releases. This includes stories on many of the individual programs within the Veterans' Administration.

The latest edition to the American Legion magazine carried an article about the prosthetic service of the department of medicine and surgery. At least half the magazines each year contain some article or at many times feature articles about a program, either medical or benefit programs, of the Veterans' Administration. We also publish VA&R bulletins and memorandums and disseminate them to the field.

We also try to update the individuals with respect to legislation that is pending, and budgetary problems—which was the focus of our Commander's message in the most recent issue of the American Legion magazine with respect to the issues that we are addressing today in the medical care area, we take every approach that we possibly can to get this word out not only to our members but everyone else who reads our publications.

Col. ROSENBLEETH. I think, Mr. Chairman, we do many similar things.

But I would like to comment as to the feeling I have. I don't think our members believe that the system is anywhere near in the danger that it really is, just as they probably don't believe that the national defense is in danger. I think people go to bed at night thinking that our country is in secure hands, and I think our members believe the VA medical system, which they remember as the best medical system in the world—which it was back in the 1950s and 1960s and maybe even later--I don't think they're fully aware of the problem.

And so I think that in spite of perhaps the literature that we send and so forth, they are probably of an average age older than I am, and people remember what they learned all their lives.

And I think inside their gut feelings, they believe the country is secure and they believe the VA health care is there. When they need it, it will be there. They're not sick, they think it's there. Nobody is attacking, they think they're safe.

I for one think that both national defense and the VA medical care are things we really need to look at. By we, I mean the country.

I work for a community relations organization too, and I was in a meeting the other day and I was surprised at how national defense and veterans are just not on the table. People have—I am not saying their concerns aren't legitimate—but they have—they name their 20 top priorities or their 50 top priorities for this country, and it doesn't touch defense and it doesn't touch the veterans.

Mr. SHERWOOD. I would make one comment. When we looked at the Triangle Research Institute study on post-traumatic stress, it basically says about 20 percent or more of Vietnam veterans, as an example, have in fact PTSD. But there are far less than 20 percent of those veterans actually utilizing the VA health care system for PTSD help.

What this means, then, if all involved veterans are informed with respect to PTSD alone, the Veterans' Administration would be overwhelmed in terms of VA workload. Only 1.2 million veterans in terms of inpatient services use the VA. But there are 27 million veterans in this country.

I think the issue then is if veterans really get to know and use the VA health care system, all veterans in terms of potentially accessing the system, particularly with a means test involving 84 percent of all veterans being served at the medical centers, can the VA deal with it?

Mr. JACKSON. I guess, in response, Mr. Chairman, to your specific question as to what the organizations are doing to make their membership aware of the situation with the VA, I would have to say that one thing for our membership, members of the NonCommissioned Officers Association, is that they are certainly aware that the Veterans' Administration medical programs, the education and the loan guarantee programs are in serious trouble.

Through letters, and contacts with our national and volunteer chapter service offices throughout the country we are constantly questioned concerning what's happening next in the VA program.

Through our monthly publication, the NCOA journal, we devote sections to Veterans' Administration programs and what the Association is doing to address them and what this committee is doing to address them.

On a biweekly basis we put out what we call our legislative update briefs, which include current information concerning things that are going on with the Veterans' Administration.

I think most of the organizations do the same such as the American Legion has pointed out, and I know most of the other organizations send out a consistent stream of information to their memberships concerning the VA.

I think we also get a great deal of feedback from our members concerning their specific experiences with the VA.

So, I don't think that it's as much of a problem as some may think, that there is a lack of information about the problems that exist today.

But I think the more people understand the problems, they are willing to offer solutions, they are willing to try to help figure out how do we solve those problems, working together, as we point out in our statement, that's going to be the key to solving this problem in the next couple of years. We are all just going to have to work together and stop worrying about who's at fault for what may be wrong. Let's work together and find solutions.

Mr. EGAN. Dr. Rowland, in your question you raised the issue of quality. The previous panel was quite articulate in discussing the quality of the research that goes on in the VA medical facilities. I don't think there is any question of the qualifications of the individuals who are conducting that research or the students who are doing their residencies in VA facilities.

But the quality of research is something that has to be distinguished from the actual quality and timeliness of care when it's delivered. Our veterans tell us—and in fact the Independent Budget is replete with references to deteriorating and poor quality of care in many of the VA's facilities. And I think as we talk about quality we need to understand that there is that distinction.

In this connection, if you are going to the VA looking for a replacement prosthetics device, you are going to wait 8 months. But if you are a nonservice-connected veteran and you need open-heart surgery, you can get that next week. There is something wrong with a system that operates that way.

Dr. ROWLAND OF GEORGIA. I think you are talking about access rather than quality of care. I wouldn't tend to disagree with you on the relationship between quality of research and quality of care. I think they are very integrally related, and I think it was pointed out earlier, if we lose our research capabilities, then we are going to begin to lose all of these other things. There is going to be a domino effect. And if we think the quality of care is poor now, we will really find out that that is not as bad as it could be.

Now, access to service is probably a different thing altogether, and certainly budgetary constraints have a lot to do with that.

I thank all of you very much for your answers.

Mr. Stump?

Mr. STUMP. Mr. Chairman, I would like to thank them all for taking the time to appear here today. We are going to be looking forward to your help and your assistance from your respective organizations later on in the sessions, and we are going to try to work out some of these problems.

Thank you very much.

Dr. ROWLAND OF GEORGIA. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

I would like to address my question to both the American Legion and the DVA. I was not in the last question the other day when

Mr. Harvey appeared, because of the intervening supplemental appropriation that was issued during that hearing.

I would like to ask a more direct question, but I understand both the VA's studies on PTSD and the American Legion's are very close in terms of the raw numbers of aggregates: the VA study, about 480,000, the American Legion stated about 500,000, the Vietnam veterans suffering from post-traumatic stress disorder. Less than 26,000 veterans are receiving any kind of compensation for PTSD.

What is your reaction basically to the last Reagan budget request where it established five additional vet centers and one additional inpatient unit in the VA hospitals?

Mr. SOMMER. Mr. Evans, there is a need for additional availability of treatment throughout the country on an inpatient basis for post-traumatic stress disorder. There are currently about 14 operating units around the country. Each one of those has a backlog. They certainly don't come anywhere near covering the need that exists nationwide.

We understand that the chief medical director's special committee on post-traumatic stress disorder, which was established by the Congress in 1984, has been looking at this very closely, and they have come up with a recommendation to develop a treatment team within each medical district.

We haven't seen the total recommendation, but it would be something worth looking into.

Mr. EGAN. The magnitude of the problem is demonstrated by the Research Triangle study, the problem of PTSD, as well as what was very strongly suggested by the Legion Columbia University study. It's far greater than anybody previously expected.

A couple more vet centers and one additional inpatient PTSD unit don't approach scratching the surface of the problem. It's just grossly inadequate, and these are pretty obviously problems that are affecting a clearly service-related disability, whether officially adjudicated as such or not.

Mr. EVANS. I want to assure you that I have submitted questions to VA, that that was an issue. I was not able to raise them in the limited time that I have today, but we will be looking at that.

Thank you, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. Mr. Sangmeister?

Mr. SANGMEISTER. Nothing in particular, Mr. Chairman, except I want also to thank everybody for taking the time to come down here.

I would like to relay to you one thing that you have to understand from my veterans organizations back home, I get the feeling now that the Cabinet status for veterans is going to take care of everything and we've got to step up. Certainly, that is going to be a big help, but that in itself is not going to be enough.

Mr. Derwinski is going to need a lot of help there. He has obviously got friends on this committee. So, all I can say to you is be sure you continue to do your homework. Don't fall into a state that the need does not exist, because money is pretty short. We will have to make some serious decisions around here. And the good old squeaky wheel, I think, concept is in vogue here.

Dr. ROWLAND OF GEORGIA. I want to thank all of you again very much for being here, and ask for your help. You are already working hard at it, but work harder because we really need to bring a lot of pressure to bear to get the Congress to realize how important the VA system is and that we need to do everything we can to maintain it.

Maybe it might be a good idea to have the National Commanders or someone high up in your organization ask to meet with Members of the Budget Committee and the Appropriations Committee. The more that we can do, the more attention we can focus on this, the better chance we have of being sure this great system that we've got doesn't deteriorate and go away.

Thank all of you again for being here.

The next panel is: Claudette Morrissey, president of the Nurses Organization of the Veterans' Administration, and a registered nurse; and Linda Schwartz, also a registered nurse of the American Nurses Association, an association of operating room nurses.

I will ask you to take the chair.

We thank all of you for being here very much.

Ms. Morrissey, if you would proceed in your own manner.

STATEMENT OF CLAUDETTE MORRISSEY, RNC, PRESIDENT NURSES ORGANIZATION OF THE VA

Ms. MORRISSEY. Thank you, Mr. Chairman.

Members of the subcommittee, I am Claudette Morrissey, a registered nurse employed full-time as a staff nurse at the Veterans' Administration medical center in Brooklyn, New York. I am here today as president of the Nurses Organization of the Veterans' Administration, and I think the committee for the opportunity to appear before you.

While I speak as the representative of NOVA, it is my goal to address the needs of the veteran patients cared for by over 32,000 registered nurses in the 172 VA hospitals and 200 outpatient clinics.

NOVA is most concerned about the adverse effect on veteran health care in the proposed 1990 VA medical budget. The administration's proposed budget, coming on top of the shortfall and the shortages we are presently experiencing, seems like a cruel joke at the expense of veteran patients and the dedicated professionals who care for them.

We cannot believe that reductions of almost 9000 total FTEEs are being considered with full knowledge of the current desperate patient care situation. It is already common that the number of nursing hours in patient care far exceeds the number of staff hours available to provide that care.

However, nursing is not the only area where there have been staff cuts or where there are shortages. When there are shortages in other departments, nurses are required to fill in the gaps as respiratory therapists, as ward secretaries, as housekeepers, and even as escorts. And when nurses are used as all-purpose, disposable employees, patients are deprived of nursing care, and the nurses get used up.

It is equally difficult to provide even adequate nursing care to our veteran patients when there is such a shortage of essential supplies. We cannot properly monitor a diabetic patient when there are no lancets to do finger sticks, no chemsticks for the blood sample, and no insulin syringes to use to give the insulin if it is needed.

This is the situation that I have been faced with over the past month at my facility, and I thank God that there have been no crises because of it.

This inadequate medical care budget has also had an adverse impact on the ability of the VA to recruit nurses. Many VA nurses report that recruitment of nursing staff is severely hampered because the VA is not competitive with local hospitals in salaries, fringe benefits, tuition reimbursement, staffing levels, weekends off, or shift rotations.

In summary, Mr. Chairman, VA nurses are being asked to do more with less in the 1990 budget. Difficulties in recruiting and retaining nurses will continue under this budget. Fewer nurses means services will be reduced and additional beds will be closed. This is not a scenario consistent with the Nation's commitment to our veterans.

Approximately $1 billion is needed beyond the President's request to keep the VA operating at last year's level. VA nurses are loyal, dedicated employees who will pull together in difficult times in order to be there at the bedside caring for the veteran patients.

However, without necessary increases, you must know that the system is dangerously close to breaking down. People can only be asked to work under pressure and without resources for so long before something will go wrong.

Perhaps you saw last week's news report where a group of patients received injections from unsterilized needles and they contracted AIDS. Now, while that happened in the Soviet Union, it is a startling reminder to us in this country that mistakes can happen when the system starts to cut corners and workers perform daily under inordinate pressure.

In addition to the increasing funds needed to meet previous service levels an overhaul of nurse pay structure is long overdue. Authorizations repeatedly adopted by this committee to provide recruitment and retention bonuses, more adequate overtime pay and cost-of-living adjustments, scholarships for nurses, continuing education,and authority for enhanced recruitment and retention activities all need to be seriously addressed and all will have budget implications.

Over 30,000 nurses in the VA system are placing their trust in you so that quality care will be provided to those who place their trust in us.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Morrissey appears on p. 455.]

Dr. **Rowland of Georgia**. Thank you very much.

Ms. Schwartz?

STATEMENT OF LINDA S. SCHWARTZ, MSN, RN, AMERICAN NURSES ASSOCIATION ASSOCIATION OF OPERATING ROOM NURSES AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES ACCOMPANIED BY: DONNA RICHARDSON

Ms. SCHWARTZ. Good morning, Mr. Chairman.

My name is Linda Schwartz. I am retired from the United States Air Force because of injuries I received in 1983. I have been service-connected disabled since that time.

I appear today as a member of the board of directors of the American Nurses Association. As you noted earlier, the Association of Operating Room Nurses and the American Association of Critical-Care Nurses join us in this testimony. The American Nurses Association has represented VA nurses in collective bargaining since 1967 through our State Nurses Association.

We thank the committee for its continued commitment to the provision of quality health care for the men and women veterans who have served this Nation. The ANA has recently endorsed The Need is Now, an Independent Budget by veterans for veterans programs.

We are concerned that the President's proposed VA budget continues a downward trend of monetary support for health care and research at the same time the VA is facing an increasing number of veteran population and an influx of older and sicker patients.

The VA once led the way in research and innovative clinical programs, but budget reductions will impede the development of new care approaches. Geriatric care and gerontological research and education must not be curtailed. We must have adequate nursing homes and manpower to provide quality health care.

As a result of FY '89 budget restrictions, we have already seen veterans' access to health care adversely impacted. VAs have closed beds and units. Chicago clinics have been told to discharge stable patients, and the future of the outreach centers, a very important work of the outreach centers is threatened.

Personally, because of my own disability, I have had to wait 3 months for an appointment regarding seeing someone to renew my medications. There has also been a reduction in nurse mix in several VA medical centers. Nurses from Illinois and California VA hospitals report freezes in employment of registered nurses and the licensed practical nurses and LPNs.

The Illinois Nurses Association reports that one VA hospital has a waiting list of 20 nurses for hire, which at this time is pretty good for having someone stand in line, because the hospital cannot foresee a ceiling of registered nurses because of the budgetary constraints.

How can we justify hiring freezes and reduction in nurse mix to veterans and VA nursing personnel during the crisis of the extreme nursing shortage we are experiencing today?

As an example of this, nurses in Pennsylvania VA hospitals have themselves gone out and sponsored recruitment teams to interest nurses in the area to come and work at the VA. These teams are at their own expense because there is very little in the recruitment budget to bring nurses into the VA.

Medical surgical nurses are rotated to emergency room and oncology units with no orientation. Managers have been instructed to increase non-RN staff to make up for RN reductions.

However, the VA cannot compete with the private sector for the licensed practical nurses or LPNs. The VA will have to use lower-skilled employees to provide health care to veterans. We are most concerned that veterans may be deprived of essential life-preserving care and treatment.

In north Chicago, if the chemotherapy nurse is on leave or ill, there is no replacement and there is no chemotherapy to the patients.

The VA's ability to provide surgical services to veterans has also been adversely impacted. Surgical suites are underutilized because of their poor condition, nor are adequate appropriately trained staff available. Operating room nurses in the VA are floated out to the medical-surgical units. We believe these trends will jeopardize the quality of care to the veterans.

The proposed budget will provide no funding for the revision of RN pay scales. Past shortfalls have meant staff cutbacks and corresponding reductions in needed services for veterans. Existing shortfalls will result in a reduction of more than 100 RNs in the northeast region alone.

Decreases have occurred in funds for staff and patient education programs and replacement or repair of equipment. Low supply levels means that veterans' care and treatment are delayed.

Basic medications such as Lasix are not available, and we have a letter that we received stating that pharmacies are running out of medications.

For example, patients on pulmonary medications and Prednisone had to be readmitted to the VA because of an exacerbation of their symptoms. The reason was they were told by the pharmacy they were out of Prednisone, which by the way is a common drug. The patient did not receive a new supply, which precipitated their symptoms and they had to be readmitted to the hospital.

This is reported by nurses in VA hospitals being a frequent occurrence. The pharmacies don't carry routine medications, and they are not available.

Congressionally mandated funds for personnel costs must be provided and not be taken away from medical care programs. We cannot continue to rob Peter to pay Paul when neither is adequately funded to meet veterans' health care needs.

Lastly and most importantly, the VA's ability to provide quality care to veterans is critically compromised by the VA's inability to compete with the private sector for nurses. Although this committee and the agency have done much to facilitate VA competitiveness, much more needs to be done.

We wholeheartedly advocate a change in the restrictive civil service pay schedules. Nursing staff and support salaries must be increased. The VA no longer leads the way with benefits such as salaries or retirement packages.

The VA must supply the necessary computer assistance for nursing, as the private sector does.

We thank you for this opportunity to address the veterans' health care issue. The ANA will continue to work with Congress and this committee and the Veterans' Administration to provide the nurses necessary to operate a health care system that is worthy of the veterans of this Nation.

Thank you.

[The prepared statement of Ms. Schwartz appears on p. 465.]

Dr. ROWLAND OF GEORGIA. Thank you very much for the statements, the very excellent statements from both of you.

Let me ask you this. How many Veterans' Administration hospitals have affiliated nursing programs? Do either of you know?

Ms. MORRISSEY. I know at the Brooklyn VA, we have three that I know of, and there might be more. We have the College of Staten Island. They come in there. We have Long Island College University comes in to work there. And Downstate, I believe, Downstate Medical Center. That is just on my surgical floor.

Now, upstairs, in the other divisions, perhaps they have other hospitals.

Ms. SCHWARTZ. I would like to just comment that the American Nurses Association is not aware of the exact number, but we do know that schools of nursing have left VA as an affiliation because there was inadequate supervision for their students on the units.

Dr. ROWLAND OF GEORGIA. But in the budget situation we have, is that affecting that affiliation, or do you know?

Ms. SCHWARTZ. Yes.

Dr. ROWLAND OF GEORGIA. A significant effect?

Ms. SCHWARTZ. Yes.

Dr. ROWLAND OF GEORGIA. Mr. Stump?

Mr. STUMP. Thank you, Mr. Chairman.

Ms. Morrissey, you mentioned a survey done by NOVA. Would you be kind enough to furnish that survey for the record?

Ms. MORRISSEY. Yes, indeed. I don't have it with me today, but I will have it tomorrow.

Mr. STUMP. Thank you.

[The information appears on p. 464.]

Mr. STUMP. We have some questions that we would submit to you for the record.

Dr. ROWLAND OF GEORGIA. We also have some questions that we would submit to youth for the record. And without objection, Members who want to submit questions for the record may do so also.

Dr. ROWLAND OF GEORGIA. Thank you for your patience in being here this morning. You certainly sat through a lot of questions.

Mr. Sangmeister, do you have any questions?

Mr. SANGMEISTER. Just one, Mr. Chairman.

It was interesting to hear your testimony because we get some of our private hospital people, administrators, in last week. Obviously, you're concerned in the Medicare area. They claim they're losing the nurses, too. If you're losing your nurses and private hospitals are losing their nurses, where are all the nurses going?

Ms. SCHWARTZ. I would like to say that at one time in my student nurse days, working in the VA was considered to be a plum because it was the best pay and it was the best place for nurses.

But now at the nursing shortage has come of age here full swing and nurses aren't being paid what they deserve to be paid, they're looking elsewhere. And it's not competitive. I come from Connecticut, the Yale-New Haven area, where we have a lot of hospitals that are offering top dollar. Nurses are leaving the VA to go take those positions.

So, whatever population of nurses are out there, it is competitive to bring them in.

Mr. SANGMEISTER. How are you compared—and I don't mean to interrupt.

Ms. MORRISSEY. I was just going to point out the fact that right here in Washington, at the Washington VA, they are having a problem because right across the driveway to the Washington Hospital Center, there was an article—I believe this was in November—the Washington Hospital Center gave their nurses a 25 percent pay raise, besides having caps lifted from salaries and so forth.

So, I would imagine right here in Washington, D.C., the VA is having a big problem.

Mr. SANGMEISTER. What about nurses going into nursing homes? How competitive are they with the VA hospitals and the private hospitals as far as attracting nurses is concerned?

Ms. MORRISSEY. Nursing homes?

Ms. RICHARDSON. I am Donna Richardson, assistant director of Congressional and agency relations for ANA.

Nursing homes are experiencing a critical nursing shortage. They experience the nursing shortage before the acute-care facilities. Most of them pay about $10 an hour, and acute-care facilities may pay up to $28 an hour.

So, the VA nursing homes, because the VA nurses get the salary, may be ahead of the game. It's just that you have more nurses working today than have ever worked before, but because of having more patients, sicker patients and more opportunities for nurses in nursing home health, HMOs, you have less nurses to spread around.

What we need are new men and women coming into nursing. So that we have adequate supplies for today. We have a shortage right now, estimated to be around 200,000. By the end of the century it is estimated to be up to 300,000 to 400,000 to meet the health care needs of the Nation—and that includes veterans. But that means that the VA is going to have to compete more with the private sector.

Mr. SANGMEISTER. Nursing was always considered one of our fine professions. Why is it there aren't enough young people interested in going into nursing? Because the pay is so bad, that there is no incentive?

Ms. MORRISSEY. Let me say the pay, the hours, the stress, the glamor isn't there for the young people. They can come out of school now and step into a job as a computer expert, a beginning computer expert, and make $30,000 to $50,000 in the first year.

I just don't think that nursing is the glamor position it was. There is too much else to offer to young people today.

Ms. SCHWARTZ. I would say that one of the major deterrents or major reasons that nurses find other ways is that, you know, you can be employed at a facility and work there for 20 years, and the pay does not increase. You know, you can be starting at $20,000 and be there 15 years and make it all the way up to $22,500. It's a salary compression, where the longevity in the profession is not rewarded in a like manner.

Mr. SANGMEISTER. I can understand that. I still think that nursing is one of the most respected professions among the public. But you have heard the old expression, you can't eat if you don't have it. We understand that.

Thank you.

Dr. ROWLAND OF GEORGIA. One other question before you leave. Is the nursing shortage relative or absolute? By that I mean is there absolutely a shortage of nurses, or are there a lot of nurses who are not in nursing now for whatever reason?

Ms. RICHARDSON. There are more nurses working as nurses than in any other profession that are working in their professional capacity.

In the 1960s you only had about 65 percent of the nurses who were working as nurses, so that when the VA and the private hospitals went out to recruit, they were bringing people in who were not working.

Now, you have over 80 percent of the nurses working as nurses in some capacity.

Dr. ROWLAND OF GEORGIA. There is an absolute shortage?

Ms. RICHARDSON. There is an absolute shortage.

Dr. ROWLAND OF GEORGIA. Thank you again very much.

The hearing stands adjourned.

[Whereupon, at 11:40 a.m., the committee was adjourned.]

APPENDIX

REMARKS OF HON. G.V. "SONNY" MONTGOMERY
ON THE FY 1990 VA BUDGET
FEBRUARY 7, 1989

The Committee will be in order.

We are meeting today to hear testimony from the Veterans Administration and several veterans organizations on the priority to be given veterans benefits and services in the next fiscal year. Prior to hearing from these witnesses, we will hear testimony from Congressman Ron Marlenee who represents the 2nd District of Montana.

Tom Harvey, Acting Administrator, will be our first witness, followed by the Independent Budget Panel from AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America and the Veterans of Foreign Wars.

Due to the large number of organizations who have requested to be heard, I have scheduled a second hearing on Thursday when we will hear from additional veterans organizations and several medical groups.

Last week, our Subcommittee on Hospitals and Health Care received testimony on the VA facility construction plans for the coming fiscal year. We learned that the construction budget had been cut almost in half from the amount originally requested by the Chief Medical Director. It was a good hearing and I don't see the need to dwell too much on the construction budget this morning.

In preparing for the hearings this week, I mailed all members of the committee an analysis of the Administration's budget which projects a continuing decline in the quality and quantity of services to veterans. What started out as a slow trickle of veterans being turned away from VA hospitals has now become a steady stream. It is taking far more time than it should to process compensation, DIC, pension, education and home loan applications. The problem seems to be lack of staff and computer time. We will not tolerate a policy that rations services to the honorable men and women who served in defense of their country.

How did we get into this situation? First of all, the budget deficit that has existed for the past several years has caused the Administration, and to a lesser degree, the Congress, to restrict the resources for veterans. It should be stated, however, that when compared with other programs (except for Defense, the space program, and the National Science Foundation), the Veterans Administration has held its own. Nonetheless, cuts have continued to come in the health care area and in the staffing of many regional offices. Year after year, the amount we've provided to fund the VA hospital system and the Department of Veterans Benefits has been less than what was needed to take care of everyone who applied. Over several years it has taken its toll. It cannot continue any longer.

In addition, we established during staff investigations and hearings last year that VA officials were not correct when they stated that the current budget would take care of any eligible veteran coming through the door of any VA hospital. Sadly, we found that they either misled the committee or did not know what was going on.

But the time for finger pointing is past. Whether it was the fault of the Administrator, the Office of Management and Budget, the Congress or a combination of all, the time has come to recognize that something must be done.

Many of us have met with Secretary-Designate Ed Derwinski in reference to the need for additional health-care and GOE funds. He has listened and I believe he will do everything he can to inform the President of the need to submit a supplemental budget to Congress. I believe he will encourage the President to submit a budget amendment for FY-89 that would add some funding to offset the shortfall for the next fiscal year.

If we fail to get the supplemental and the additional funds for FY-90, there will be some very hard times ahead for all of us. It may be that some hospital mission changes will have to be made. It may even be necessary to consolidate or close some hospitals. I hope not. But we cannot continue to take across-the-board cuts in all hospitals. Otherwise, the quality of care is going to be adversely affected.

Let me close by saying this to my colleagues, Administration officials, and to the veterans organizations who are gathered here. Last year we saw legislation enacted making the VA a cabinet level department. I am proud of the role many of us played in that achievement. But I want to emphasize that the reason it got done is because veterans wanted it done. They united behind a common goal, they rallied their members, they lobbied members of the committees involved. The National Commanders came into town and met personally with Members. In short, the veterans organizations did what it took to get the attention of the Members. So the message I have for the veterans organizations this morning is this. If you want the government to respond to the present funding shortfall, you cannot leave here thinking that your job is done. Veterans have always had a sympathetic ear in this Committee. But in the world where veterans must compete with other interest groups, the Congress has not been so sympathetic. For instance--

Medicaid spending has grown by 55% since 1985.

Medicare spending has grown by 32%.

Veterans health care spending has grown by only 17%.

Veterans are falling behind. If you want to succeed, you must get every one of your Members, and many who are not your Members, to insist that when it comes to funding priorities, veterans should be number one. So when you leave here today, go see the Members of the Budget Committee who are responsible for setting spending priorities. Go talk with members of the Appropriations Committees. Those two committees are the key to our success. I plan to meet with the Chairman of the Budget Committee very shortly. I have scheduled a meeting with the Honorable Bob Traxler, Chairman of the Subcommittee on HUD and Independent Agencies tomorrow and I urge the veterans organizations to do the same. If you do your job, you can get the job done.

Statement of the Honorable Bob Stump before the Veterans' Affairs Committee Regarding DVA FY 90 Budget

Thank You Mr. Chairman.

This is my first hearing as Ranking Member of the Veterans' Affairs Committee and I could not be more pleased to be here with you as Chairman. Your complete commitment to our Nations' Veterans is well known and shared by me.

Mr. Chairman, in today's hearing on the Fiscal Year 1990 VA Budget, let's get right to the point. The VA is in nothing less than a funding crisis. We already know there isn't enough money for the current fiscal year, and it certainly appears that the proposed Fiscal 90 budget is seriously deficient too.

It concerns me that the proposed budget calls for a current reduction in hospital, nursing home and domiciliary services at a time when the need for them is growing. The proposed budget doesn't even come close to keeping up with inflation, though inflation has been quite low.

We should insist that Veterans' programs remain among the highest national priorities, and Mr. Chairman, I am prepared to join with you in working for supplemental funding for the current fiscal year and for an adequate budget for fiscal 1990.

Veterans don't expect anything fancy,but they have every right to expect quality health care, accurate and prompt processing of their claims for benefits, and reasonably efficient delivery of those benefits they are entitled to. With the proposed budget before us, all these are jeopardized. With our combined efforts, Mr. Chairman, the bipartisan support of every member of this Committee and the help of the veterans' service organizations, I believe we can turn the situation around. America's veterans may rest assured that we will give them our very best effort.

I look forward to working with you Sonny. I join you in welcoming our witnesses and am most anxious to learn more about the fiscal '90 budget from them today and Thursday.

Thank You, Mr. Chairman.

Congreſs of the United States
House of Representatives
Washington, DC 20515

COMMITTEE ON VETERANS AFFAIRS

FEBRUARY 7, 1989

OPENING STATEMENT

MR. CHAIRMAN, REPUBLICAN AND DEMOCRATIC COLLEAGUES,

VETERANS, IT IS AN HONOR AND A PRIVILEGE TO BE HERE TODAY AS WE CONSIDER TESTIMONY ON THE PROPOSED FISCAL YEAR 1990 VETERANS ADMINISTRATION BUDGET. I REPRESENT THE 4TH CONGRESSIONAL DISTRICT OF FLORIDA, AN AREA THAT SPANS FROM JACKSONVILLE TO DAYTONA BEACH AND WESTWARD TO SEMINOLE AND LAKE COUNTY LINES. WE HAVE A LARGE AND GROWING VETERAN POPULATION. I SOUGHT APPOINTMENT TO THIS COMMITTEE BECAUSE THE DECISIONS MADE HERE IMPACT SO GREATLY ON MY CONSTITUENTS.

OUR VETERANS MADE MANY SACRIFICES FOR OUR COUNTRY, AND,CURRENTLY, WE ARE NOT PROVIDING THE KIND OF QUALITY CARE THESE MEN AND WOMEN DESERVE.

LET ME SAY THAT I AM GREATLY DISAPPOINTED AT THE LACK OF PROPOSED FUNDING FOR CRITICALLY NEEDED VETERANS PROGRAMS IN THE FY'90 BUDGET. THE AMERICAN VETERAN POPULATION IS GROWING OLDER, AND THE NEED FOR INCREASED SERVICES IS GROWING RIGHT ALONG WITH IT. IT DOESN'T MAKE SENSE TO CUT BACK SERVICES WHEN VA HOSPITALS AND PROGRAMS ARE UNDERSTAFFED AND THE NUMBER OF VETERANS ULTILIZING THE VA PROGRAMS IS INCREASING TREMENDOUSLY.

THIS PROPOSED SPENDING PLAN WOULD REDUCE MEDICAL FACILITY CONSTRUCTION, ELIMINATE NEARLY 9 THOUSAND VA HEALTH CARE JOBS, AND DENY MEDICAL CARE TO THOUSANDS OF DESERVING VETERANS.

I FAIL TO SEE THE LOGIC TO MAKE ACROSS THE BOARD CUTBACKS WHEN

THE NEED FOR SERVICES IS INCREASING SO RAPIDLY.

WE HAVE A DUTY TO PROVIDE FOR OUR VETERANS.

WE MUST EXPAND VETERANS SERVICES, IMPROVE THE DELIVERY SYSTEM, AND RE-EXAMINE THE ENTIRE FORMULA BY WHICH WE DISTRIBUTE BOTH HEALTH CARE AND MONETARY BENEFITS.

IN MY DISTRICT, THERE ARE CONCERNS OVER THE PLANNED RELOCATION OF 20 of 30 beds IN THE SPINAL CORD INJURY UNIT AT THE GAINSVILLE VA HOSPITAL, AS WELL AS THE LACK OF A LONG-TERM PSYCHIATRIC CARE FACILITY ANYWHERE IN THE STATE OF FLORIDA.

I MIGHT ADD, THAT FLORIDA IS THE ONLY ONE OF 27 VETERANS ADMINISTRATION REGIONS THAT DOES NOT HAVE A LONG-TERM PSYCHIATRIC CARE FACILITY. A FACILITY HAS LONG BEEN PLANNED, BUT MONEY FOR CONSTRUCTION FAILS TO APPEAR IN THE FY'90 BUDGET.

I AM ALSO VERY CONCERNED ABOUT THE VA HEALTH CLINIC IN DAYTONA BEACH. ANY ADJUSTMENT IN FUNDING TO GAINSVILLE, DIRECTLY EFFECTS THE DAYTONA BEACH VA CLINIC.

I FULLY UNDERSTAND THAT WE HAVE MAJOR MONEY PROBLEMS. WE ARE KEEPING A CLOSE EYE ON FEDERAL SPENDING, BUT WE CANNOT OVERLOOK THE NEED TO PROVIDE QUALITY CARE AND SERVICE TO OUR NATION'S 27 MILLION VETERANS.

WE HAVE AN OBLIGATION TO BE THERE FOR THEM. THEY SERVED AND SACRIFICED FOR THIS NATION SELFLESSLY, WITH PATRIOTISM, COURAGE, AND HONOR. WE MUST NOT ABANDON THEM IN THEIR TIME OF NEED.

I LOOK FORWARD TO WORKING WITH SECRETARY DERWINSKI,THE ESTEEMED CHAIRMAN AND RANKING MINORITY MEMBER OF THIS COMMITTEE, AND MY COLLEAGUES TO ACT IN THE BEST INTERSTS OF OUR NATION'S VETERANS AND THEIR FAMILIES.

THANK YOU.

REMARKS OF THE
HONORABLE HARLEY O. STAGGERS, JR.
FEBRUARY 7, 1989
FULL COMMITTEE BUDGET HEARING

MR. CHAIRMAN, I AM TRULY APPALLED AT THE PROPOSALS CONTAINED IN THE ADMINISTRATION'S BUDGET. SO APPALLED, THAT I HAVE DECIDED TO SCHEDULE MY OWN SEPARATE HEARINGS ON THE ADMINISTRATION'S BUDGET PROPOSALS WHICH FALL UNDER THE JURISDICTION OF THE SUBCOMMITTEE ON HOUSING AND MEMORIAL AFFAIRS.

ALTHOUGH I WILL ASK A FEW QUESTIONS TODAY, I WILL OBVIOUSLY EXPLORE THESE ISSUES IN GREATER DEPTH ON THURSDAY. I WOULD INVITE ANY MEMBER WHO HAS AN INTEREST IN THESE PROGRAMS TO ATTEND THIS HEARING WHICH WILL BEGIN AT 1:00 P.M. IN ROOM 334.

SOME OF THE ISSUES WE WILL BE ADDRESSING WILL BE CREDIT REFORM WHICH WOULD MANDATE THAT A SEPARATE ACCOUNT BE SET UP AT THE TREASURY DEPARTMENT; INCREASING THE USER FEE FROM 1 TO 3.8%; REPEALING THE VA'S CURRENT AUTHORITY TO ESTABLISH MAXIMUM INTEREST RATES; RESTRUCTURING THE LAW PERTAINING TO LOAN ASSET SALES. WE WILL ALSO LOOK AT THE VA'S CHANGE IN REGULATIONS TO INCLUDE THE COST OF GOVERNMENT BORROWING IN THEIR DETERMINATION AS TO WHETHER TO ACQUIRE OR NOT ACQUIRE FORECLOSED PROPERTIES.

OPENING STATEMENT - CONGRESSMAN CLIFF STEARNS

COMMITTEE ON VETERANS AFFAIRS 2/7/89

Thank you Mr. Chairman. I am proud to be here today representing the veterans of my district and throughout Florida.

Today we will address the budget for the Department of Veterans Affairs for FY 1990. I look forward to working with you all on this issue which is so crucial to this country's former servicemen and women.

This year a record number of veterans will come south to live and work in sunbelt states. Unfortunately, the resources available to provide medical care and other services has not kept up with the demand for these services.

Health care is a particularly troublesome aspect of cuts in DVA funds. Many veterans who were able to receive care in other states because they fall into the category of veterants who "may" receive care in a VA facility do not receive care in Florida because the majority of dollars go toward services for the "shall" category of vets. Equity of access will be an issue for discussion this year, and hospitals in regions outside the southeast have already had funds diverted to meet the growing need in our area. But we're not doing enough. Beds which could easily be filled with patients are empty because there is simply not enough money flowing in states where the need is greatest.

For this reason, I hope that the committee will be mindful of the phenomenal growth in states like Florida, and will give them special consideration when resources are allocated during our budget discussions.

I look forward to these hearings and to my service to this committee and my constituents.

STATEMENT OF THE HONORABLE THOMAS E. HARVEY
ACTING ADMINISTRATOR OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
FEBRUARY 7, 1989

Mr. Chairman and Members of the Committee, I appreciate this opportunity to appear before you today to present the Reagan Administration's FY 1990 budget for the Department of Veterans Affairs (VA). The Reagan budget request $30 billion in new budget authority to fund medical, compensation, and other programs for the Nation's 27.3 million veterans, eligible members of their families, and survivors of deceased veterans. As your are aware, President Bush is expected to present revisions to the Reagan Budget on February 9, 1989.

Included in this amount is an appropriation request for $28.6 billion, net savings of $84 million related to proposed legislation and $1.4 billion through permanent authorizations. President Reagan's FY 1990 request for the VA represents an increase of approximately $193 million above the current estimate for FY 1989. Reagan budget outlays for FY 1990 are estimated at $29 billion. Average employment (FTEE) is expected to decrease by 5,019 from the 1989 current estimate to a level of 213,143.

I would like to emphasize that providing quality medical care and benefits to America's veterans is one of our highest priorities. Included in President Reagan's budget are funds to support initiatives designed to utilize modern technology that will improve the delivery of all benefits and services to eligible veterans. The Reagan budget also includes funds for the expansion of the system by funding a new hospital in West Palm Beach, Florida and funding a new national cemetery in Northern California.

In the area of medical care, the Reagan budget provides sufficient resources to provide hospital and outpatient care to those veterans whose care is mandated by statute. Care will continue to be provided to all service-disabled veterans who request it, as well as to former prisoners of war, veterans exposed to toxic substances and radiation, and all lower and middle income veterans as well as to some higher income veterans who apply. The Reagan budget request provides for 1.2 million episodes of inpatient care and 23 million outpatient visits. As indicated by the continuing drop in length of stay for inpatients, the demand is being met by the introduction of new technology which increases productivity and improves the services provided by our medical personnel.

The Reagan budget request for 1990 also includes funds that will provide for the establishment of an adjudication academy. This facility, which will be established at the Washington Regional Office, will allow the Veterans Benefits Administration (VBA) to provide a centralized, comprehensive training program to approximately 120 adjudicators in 1990.

I will now summarize the Reagan Administration's FY 1990 budget request for the VA, highlighting the budget issues for each of the major accounts.

Compensation

The 1990 Reagan budget requests $11.2 billion, under existing law, to provide compensation payments to 2.2 million veterans and 326.5 thousand survivors. The 1990 funding request, included in the Reagan budget, reflects the full year impact of the 4.1 percent compensation rate increase provided to all recipients effective December 1, 1988.

The Reagan budget proposes legislation to index compensation benefits to the annual change in the Consumer Price Index. Enactment of this proposal would guarantee that all compensation recipients are provided a full and timely cost-of-living adjustment. It is currently estimated that the first such "automatic" cost-of-living adjustment, effective December 1, 1989, will be 3.6 percent and cost approximately $318 million.

Pensions

The 1990 Reagan budget submission includes an appropriation request of $4.0 billion. This amount is needed to provide payments to 1.1 million eligible recipients. The 1990 caseload estimate is 54 thousand below the 1989 estimate. The caseload reduction reflects a continuing trend in this program. Although it is anticipated that the number of veterans age 65 and older will increase during this decade, improvements in retirement benefits as well as other income sources will result in the continued decline in pension caseload.

The 1990 Reagan budget request includes the full year impact of the 4.1 percent cost-of-living increase provided to Improved Law recipients in December 1988, as well as an estimated 3.6 percent cost-of-living adjustment which would be effective in December 1989. The cost-of-living adjustments to eligible pension recipients, by law, are based upon the actual change in the Consumer Price Index.

Burial Benefits and Miscellaneous Assistance

For 1990, President Reagan requested an appropriation of $152.6 million to support operations in the Burial Benefits and Miscellaneous Assistance appropriation.

The Reagan budget proposes legislation to change the eligibility requirement for the burial plot allowance to be consistent with the eligibility requirement for the basic burial allowance, with the exception that veterans who are buried in State Cemeteries will continue to remain eligible. Enactment of this legislation is estimated to save $36.5 million in 1990.

Readjustment Benefits

An appropriation of $434.1 million is requested in President Reagan's FY 1990 budget to operate the programs funded by the Readjustment Benefits appropriation. This funding level will provide benefits to 91,600 veterans and servicepersons training under the Vietnam era G. I. Bill program, as well as basic education benefits to 78,600 veterans under the new Montgomery G. I. Bill. The basic benefits for veterans and servicepersons as well as payments for reservists under the new program will be enhanced with a $137 million transfer, primarily from the Department of Defense, which will be used to finance benefits to veterans, reservists and servicepersons. Education benefits under the older programs will also be provided to 38,800 dependents and vocational rehabilitation to 22,700 disabled veterans.

These programs are in a transition as eligibility for the new Montgomery G. I. Bill gradually replaces eligibility for the older programs. The trainee level under the older programs is estimated to be 68 thousand fewer in 1990 than in 1989 but the trainee level under the new program is expected to be 53 thousand higher. As more individuals become eligible for benefits, the number of trainees will continue to increase.

The Reagan budget proposes legislation to increase dependents' assistance allowances and vocational rehabilitation subsistence allowances by five percent effective January 1, 1990. This is estimated to result in additional obligations of $5.2 million in 1990.

Loan Guaranty

An appropriation of $453 million would be necessary under existing law in 1990 to support operations in the Loan Guaranty Revolving Fund. However, considering the proposed legislation, the Reagan budget requests $251 million. This appropriation request would fund nearly $3.6 billion in obligations estimated for 1990. It is projected that nearly 178,000 loans totaling $13.9 billion will be guaranteed in 1990.

The 1990 Reagan budget proposes legislation to grant the Secretary of VA more flexibility to sell loans with or without recourse. Current legislation prohibits the selling of loans after 1989 without recourse, unless they can be sold at par. Non-recourse sales offer the advantage of limiting the Government's future liability. If enacted, it is estimated that net proceeds from non-recourse loan sales will be realized in the amount of $535.2 million.

The Reagan budget also assumes legislation to increase and make permanent the funding fee, effective October 1, 1989 from one percent to 3.8 percent of the loan amount on guaranteed and vendee (direct) loans. Revenue to the fund estimated for 1990 from this legislation is $534.3 million.

Under the Reagan budget, we anticipate changing VA regulations to include the government's cost of borrowing as a Federal cost in the determination of whether to acquire or not acquire foreclosed property. We estimate that this change will save $187 million and will result in the acquisition of 10 percent fewer properties.

Moreover, the Reagan budget is proposing legislation to allow veterans to negotiate the interest rate on VA-guaranteed mortgages, providing maximum flexibility to veterans to structure the financing of their home purchases to best meet their needs.

The FY 1990 Reagan budget continues to propose a Credit Reform initiative that explicitly recognizes the benefit, or grant, received by a borrower in obtaining a federal guaranty for repayment of the borrower's debt and thereby obtaining credit under more favorable terms than from the private sector. It is estimated that the subsidy, or grant, of $833 million is associated with the guaranty of $13.9 billion in home loans in 1990. Enactment of these initiatives will have no impact on the veterans' ability to obtain guaranteed home loans from private lenders with no down payment.

GENERAL OPERATING EXPENSES

A total of $803.6 million is requested for the General Operating Expenses appropriation in the 1990 Reagan budget. This funding level, which is $29.2 million above the 1989 level, will support an average employment level of 16,797.

The 1990 Reagan budget request for the Veterans Benefits Administration (VBA), formerly the Department of Veterans Benefits, is $548.8 million with an average employment level of 12,100. This resource level is $33 million above the 1989 level while average employment decreases 550. Approximately one half of this reduction reflects the transfer of 227 FTEE to the Veterans Health Services and Research Administration. These employees, who were assigned to VBA, provided administrative support to the health services activity.

Included in VBA's budget request is nearly $25.1 million to support the Twelve Point Plan for modernization. The modernization initiative will allow VBA to improve the delivery of benefits and services through technology. It is anticipated that 167 FTEE will be saved through implementation of several modernization initiatives in 1990.

In addition, the Reagan budget proposes legislation that would allow the funding of the Loan Production System (LPS) from the Loan Guaranty Revolving Fund in 1989. This will result in a savings of $4.4 million and 1.7 FTEE from the FY 1990 GOE request in addition to providing savings in the Loan Guaranty Revolving Fund. This automation effort is designed to improve the timeliness in the processing and monitoring of applications, valuating properties, assigning appraisers and, when necessary scheduling inspections.

In its modernization efforts, VBA is faced with three issues. These issues are to address a long-term solution, implement short term initiatives, and continue operation of the existing benefits delivery system. In 1990, the Reagan budget requests funding for six short-term initiatives. These initiatives will greatly enhance services to veterans by automating manual processes.

Among the 1990 Reagan budget initiatives is the continuation of the paperless file project. The prototype system, which includes the utilization of optical disk storage rather than paper files, is being used for the processing of Montgomery GI Bill education benefits. By eliminating the need to search for paper files, the VA can process claims and respond to veterans' inquiries in minutes rather than days. VBA's efforts in this area were recognized as the "Innovative Solution of the Year" by the Management Information Systems Week, a national trade publication.

The 1990 Reagan budget includes nearly $3.8 million to evaluate the cost effectiveness of having the private sector manage and resell approximately ten percent of the VA's property inventory.

The 1990 Reagan budget request for the National Cemetery System of $48.8 million and 1,238 FTEE is $3.2 million and 35 FTEE above the 1989 level. The budget request for the National Cemetery System will provide the resources necessary for an estimated 60,500 interments (a 2,000 increase from the 1989 level); the maintenance of over 1.8 million gravesites (a 48,800 increase from the 1989 level), as well as resources for the Northern California cemetery which is scheduled to open in 1991. Personnel for the maintenance of the cemetery in Arizona are included in the 1,238 FTEE request.

In addition, the Reagan budget requests $4.4 million to continue the Grants for the Construction of State Cemeteries. It is estimated that these resources will allow at least four states to participate in this program in 1990.

The Reagan budget requests $205.9 million and 3,459 FTEE for General Administration. This represents a decrease of $6.9 million and 460 FTEE from the 1989 level. The primary reason for the reduction is that in 1990, the Office of Inspector General becomes a separate appropriation. The 1989 resource level includes $20.5 million and 377 FTEE for the Office of Inspector General.

Included in the Reagan budget is $1.9 million to upgrade and expand the Austin DPC system. The increase in computer capacity is necessary to support future demands on the system resulting from an increased reliance upon on-line ADP systems.

In other ADP initiatives, the VA is requesting funds to continue the development of the Financial Management System (FMS); the Personnel Accounting and Integrated Data Systems (PAID) and begin the development of the Management and Decision Support Systems (MADSS).

A total of $1.7 million and 28 additional FTEE are requested in the Office of General Counsel for anticipated workload resulting from judicial review legislation.

Finally, in 1990, the Reagan budget requests $22.2 million and 397 FTEE for the Office of Inspector General. As a result of Public Law 100-504, the Office of Inspector General will be funded in a separate appropriation in 1990. The 397 FTEE level, which represents a 20 FTEE increase over the 1989 estimated level, is in accordance with the guidelines stated in Public law 100-527.

Medical Care

The FY 1990 Reagan budget is requesting $10.7 billion for direct medical care, an increase of $198.9 million over FY 1989, with an average Federal employment level of 186,194 in the health care system and an additional 2,929 staff hired by contract.

The FY 1990 Reagan budget will allow the VA to provide quality health care to an estimated 1.2 million inpatients and for 23 million outpatient visits in a nationwide medical care system.

The Reagan budget provides for the effects of expected inflation, for the funding and staffing requirements associated with opening new facilities, for increased payroll costs, and for several new and expanded initiatives. The initiatives involve areas such as: a $61.6 million increase for emphasis on AIDS patients and universal precautions for high-risk medical employees; a $50.9 million increase for 423 additional extended-care nursing beds; $17.6 million in net savings from the Decentralized Hospital Computer Program (DHCP); $1.6 million enhancement of treatment for Post-Traumatic Stress Disorder (PTSD) program; and $1.8 million for VA Learning Opportunities Residency (VALOR) program which is a recruitment tool to increase the number of registered nurses in hard to recruit clinical areas.

The Reagan budget also includes legislative proposals saving $86 million that would: (a) expand upon current law by authorizing reimbursement from private health insurers for treating non-service-connected medical conditions of insured veterans who have 0 percent to 20 percent service-connected disabilities yielding $62 million in receipts; (b) require veterans who do not have service-connected disabilities and who are in the middle or higher income categories to make nominal co-payments for outpatient visits ($5-$10), outpatient prescriptions ($3-$5) and a $9 per-diem payment for inpatient treatment generating $24 million in receipts; (c) raise the limit on authorized dental treatment that can be performed without a second opinion from $500 to $1,000, as well as permit dental treatment in certain instances on an outpatient basis that is currently performed on an inpatient basis, saving $707 thousand.

Medical and Prosthetic Research

The 1990 Reagan budget request for Medical and Prosthetic Research is $197.3 million and 4,106 FTEE, a decrease of $12.9 million and 616 FTEE from 1989, returning the program to the funding levels just above those for FY 1985 through FY 1988.

Funding is being requested for medical research in the areas of heart disease, schizophrenia, spinal cord injury, diabetes, cancer, aging, alcoholism, and an increase for AIDS. There is also support for related problems of Vietnam-era veterans, former prisoners of war and female veterans.

Funding is also being requested to continue support for rehabilitation research in the priority areas of prosthetics/amputations, spinal cord injury, and sensory aids.

Medical Administrative and Miscellaneous Operating Expenses (MAMOE)

The 1990 Reagan request for this program is $48.5 million, an increase of $0.6 million over 1989. Staffing would be reduced 6 FTEE from the 1989 level of 595 FTEE. The Health Professional Scholarship Program would be funded at a slightly higher level than 1989.

Grants for Construction of State Extended Care Facilities

The 1990 Reagan request for this program is $42 million, the same level as 1989. This funding provides for 760 new nursing home beds and 326 domiciliary beds. These funds will allow the VA to continue shifting the mix of VA-sponsored care towards cost effective state nursing home alternatives, while expanding the total amount of nursing care available to veterans.

Construction

The 1990 Reagan request for the construction appropriations is $487.6 million. Of this amount, $365.8 million is for major projects at medical centers, regional offices and national cemeteries.

Major construction funds are proposed for eleven medical facilities, including two replacement and modernization projects--construction funds for modernization of the Newington, CT facility and the new facility at Palm Beach, FL. Also requested are funds for a Fire and Safety Improvements Project at the Waco, TX facility; renovation of medical buildings at the Salt Lake City, UT facility; construction of a new psychiatric building at the Columbia, SC facility; construction of an Outpatient Clinic at the Dublin, GA facility; and a joint venture with the Department of the Air Force for construction of a new medical facility at Nellis Air Force Base.

Funding is also included for additional gravesite development at the Jefferson Barracks National Cemetery and the Fort Snelling National Cemetery.

For minor construction, the 1990 Reagan request is $114.7 million. The FY 1990 budget proposes that the ceiling for minor construction projects be increased from $2 to $3 million. Minor construction includes a General Administration limitation of $45.1 million.

In FY 1990, the Reagan budget requests $7.1 million in new budget authority for the Parking Garage Revolving Fund to be used for the new parking garage that is planned for construction in connection with the new Palm Beach VA medical center.

Closing

Mr. Chairman, in closing, we are committed to the accomplishment of the VA's mission to provide veterans the care, support and recognition they have earned in service to this Nation. Our budget request reflects both this commitment to meeting the needs of our veterans as well as a concern for fiscal restraint. This concludes my introductory statement.

My staff and I will be pleased to discuss the details of this request and answer your questions and those of the Committee Members.

OPENING STATEMENT OF CONGRESSMAN JOE KENNEDY, II

I WOULD LIKE TO BRIEFLY FOCUS ON THE VA MEDICAL BUDGET.

IT WAS NOT LONG AGO WHEN THIS COMMITTEE HELD HEARINGS ON THE STATUS OF THE VA MEDICAL BUDGET.

IT WAS NOT LONG AGO WHEN THE VA CHIEF MEDICAL DIRECTOR CONCEDED THAT THERE EXISTED A $635 MILLION BUDGET SHORTFALL FOR THE DEPARTMENT OF MEDICINE AND SURGERY.

IT WAS NOT LONG AGO WHEN WE HEARD FROM HOSPITAL ADMINISTRATORS THAT SERVICE-CONNECTED VETERANS WERE BEING TURNED AWAY FROM HOSPITAL DOORS,

AND THAT SAME DAY WE HEARD FROM VA NURSES THAT BECAUSE OF SEVERE STAFFING SHORTAGES, VETERANS ARE RECEIVING SUBSTANDARD MEDICAL CARE AND ARE BEING PLACED IN AN OBVIOUS SITUATION OF RISK WHEN ENTERING CERTAIN VA MEDICAL CENTERS.

And it was not long ago when the Administrator of the VA promised to work with this committee and go to the White House in order that we can take care of the serious deficiencies that currently exist.

Five months later, I'm staring at a budget proposal that does not even provide for a modest inflation increase over last year's budget.

The same budget proposal calls for a decrease of 17,516 patients treated in VA HOSPITALS when we can document that access to medical care has already been reduced.

The same budget proposal calls for a decrease of 14,252 patients treated in long-term care facilities when we can document that chronically ill vets are taking up acute care beds because there are no long-term beds available.

THE SAME BUDGET PROPOSAL CALLS FOR A DECREASE OF 2,400,000 OUTPATIENT VISITS AT THE SAME TIME WHEN HOSPITAL ADMINISTRATORS ARE BEING URGED TO SHIFT TO OUTPATIENT CARE IN AN ATTEMPT TO SAVE INPATIENT DOLLARS.

THE SAME BUDGET PROPOSAL CALLS FOR A DECREASE OF 8,256 FULL-TIME MEDICAL POSITIONS WHEN THE VA MEDICAL CARE PERSONNEL SHORTAGE IS SO SEVERE THAT WARDS HAVE BEEN CLOSED AND PATIENT CARE SERVICES CUT BACK.

MAYBE THE WITNESSES HERE CAN TELL ME, HAS THE SITUATION AT THE VA DRAMATICALLY CHANGED SO THAT THE 13,000 BEDS REPORTED OUT OF SERVICE LAST YEAR ARE NOW STAFFED AND OPERATING,

OR HAS THE 7000 PERSONNEL VACANCIES WHICH WERE DUE TO RECRUITMENT PROBLEMS BEEN FILLED?

OR HAS THE RECURRING OPERATING EXPENSES BEEN FULLY FUNDED SO THAT THERE WILL BE NO NEED TO DIVERT ANOTHER $60 MILLION FROM THE MAINTENANCE AND EQUIPMENT BUDGET WHICH OCCURRED LAST YEAR?

I WILL BE VERY INTERESTED IN HEARING FROM OUR PANEL OF EXPERTS ON THE POINTS THAT I JUST OUTLINED.

THANK YOU.

EXCERPT FROM DEPARTMENT OF DEFENSE REPORT ON VA/DOD HEALTH CARE RESOURCES SHARING PROGRAM

Type and Number of Procedures	Cost per Procedure in Civilian Non-Federal Facility	Cost per Procedure in VA Facility	Total Cost Difference Civ. vs VA
Bone Scan/161	$407.11	$ 76.09	$53,294.22
Thyroid Scan/67	$337.42	$ 33.18	$20,384.08
Inpatient Psychiatric	$394.50 per Day	$236.00 per Day	

3) England Hospital, England AFB, Louisiana

England Hospital has a sharing agreement with the Alexandria VAMC to refer patients for a number of different outpatient and inpatient tests. Under these agreements the MTF's cost avoidance can be seen in the following differences between what they paid for 30 tests at the VA and 15 inpatient admissions and what they would have paid for the tests in the non-federal civilian sector:

Type and Number of Procedures	Total Cost in Civilian Non-Federal Facility	Total Cost in VA Facility	Total Cost Difference Civ. vs VA
Outpatient Tests	$ 9,409.00	$ 2,761.00	$ 6,648.00
Scans/17	($5,905.00)	($1,985.00)	($3,920.00)
Nerve Conducting/8	($3,200.00)	($ 660.00)	($2,540.00)
Other/5	($ 304.00)	($ 116.00)	($ 188.00)
Inpatient Adm./15	$78,000.00	$26,319.00	$51,681.00

4) Walter Reed Army Medical Center (AMC), Washington D.C.

Walter Reed AMC signed a sharing agreement with the DC VAMC to refer patients for emergency health care, neurological testing and ultra sound. Walter Reed paid the VA $72,288.00 for the care in FY 88, and would have spent $120,000.00, or $47,712.00 more, for the same care in the civilian sector.

5) Womack Army Community Hospital (ACH), Fort Bragg, North Carolina

Womack ACH signed a sharing agreement with the Fayetteville VAMC for routine lab work, including blood work which is a high volume item. Womack paid the VA $83,720.00 for the care in FY 88, and would have spent $218,896.00, or $135,176.00 more, for the same care in the civilian sector.

6) Dwight David Eisenhower AMC, Fort Gordon, Georgia

Eisenhower AMC signed a sharing agreement with the Augusta VAMC for angioplasty. The VA charged $495 a day while the civilian charge was approximately $1,500 a day. Eisenhower paid the VA $44,500.00 for the care in FY 88, and would have spent $400,000.00, or $355,500.00 more, for the same care in the civilian sector.

Honorable Claude Harris
Statement for the Record
February 7, 1989

The Reagan Administration's proposed spending plan for veterans' programs for fiscal year 1990 represents a $786 million reduction from the fiscal year 1989 budget that funds current services of the Veterans Administration.

This plan represents a complete departure from the facts. The OMB (Office of Management and Budget) continues to ignore the growing demand by older veterans for health care services in the coming years. Not only do they reduce personnel for the hospitals, but also the planner base their projects on a declining number of visits each year by veterans. Next year, they suggest that over 17,000 fewer veterans will seek help from the VA hospitals.

During the Reagan Administration, veterans benefits have been reduced and altered. Today all veterans who seek medical services are classified by income and service-disability. The VA hospitals prioritize their services according to these categories. In addition, veterans' pensions have been limited to either veterans with service-connected disabilities or non-service connected veterans and their widows who possess few assets.

The veteran population has already tightened its belt. No longer do we provide wealthy veterans with free services. Veterans will do their share, in fact, they have led the way, in our efforts to reduce the federal deficit. There is no doubt in my mind that need veterans will be denied care and other benefits if this budget is agreed to.

In addition to the elimination of nearly 9,000 full-time personnel in the medical services department, the budget cuts $180.3 million from the construction budget, increases the origination fee from 1% to 3.8% for veterans using the VA-guaranteed home loan program, reduces the medical and prosthetic research budget by $12.9 million, eliminates the veterans' job training and veterans' education loan fund, reduced funding for the VA burial benefits by $36.5 million, and repeals the travel allowance for most veterans.

This plan certainly does not meet the needs of today's veterans. I anxiously await President Bush's recommendations for veterans' programs to ascertain his support for veterans. It is not enough to add another chair at the table, referring to the new cabinet status of the Department of Veterans Affairs, at the same time he's cutting beds in the hospitals and nursing homes.

DRGs Used in VA Hospitals

DRG	MDC	DRGNAME
1	1	Craniotomy age >=18 ex for Trauma
2	1	Craniotomy for Trauma age >=18
3	1	Craniotomy for Trauma age <18
4	1	Spinal Procedures
5	1	Extracranial Vascular Procedures
6	1	Carpal Tunnel Release Procedure
7	1	Periph or Cranial Nerve & Other Nervous System Procedures age >=70 &/or CC
8	1	Periph or Cranial Nerve & Other Nervous System Procedures age <70 w/o CC
9	1	Spinal Disorders & Injuries
10	1	Nervous System Neoplasms age >=70 &/or CC
11	1	Nervous System Neoplasms age <70 w/o CC
12	1	Degenerative Nervous System Disorders
13	1	Multiple Sclerosis & Cerebellar Ataxia
14	1	Specific Cerebrovascular Disorders ex TIA
15	1	Transient Ischemic Attacks (TIA)
16	1	Nonspecific Cerebrovascular Disorders w/ CC
17	1	Nonspecific Cerebrovascular Disorders w/o CC
18	1	Cranial & Peripheral Nerve Disorders age >=70 &/or CC
19	1	Cranial & Peripheral Nerve Disorders age <70 w/o CC
20	1	Nervous System Infection ex Viral Meningitis
21	1	Viral Meningitis
22	1	Hypertensive Encephalopathy
23	1	Nontraumatic Stupor & Coma
24	1	Seizure & Headache age >=70 &/or CC
25	1	Seizure & Headache age 18-69 w/o CC
26	1	Seizure & Headache age <18
27	1	Traumatic Stupor & Coma, Coma >1 Hr
28	1	Traumatic Stupor & Coma, Coma <1 Hr age >=70 &/or CC
29	1	Traumatic Stupor & Coma <1 Hr age 18-69 w/o CC
30	1	Traumatic Stupor & Coma <1 Hr age <18
31	1	Concussion age >=70 &/or CC
32	1	Concussion age 18-69 w/o CC
33	1	Concussion age <18
34	1	Other Disorders of Nervous System age >=70 &/or CC
35	1	Other Disorders of Nervous System age <70 w/o CC
36	2	Retinal Procedures
37	2	Orbital Procedures
38	2	Primary Iris Procedures
39	2	Lens Procedures
40	2	Extraocular Procedures ex Orbit age >=18
41	2	Extraocular Procedures ex Orbit age <18
42	2	Intraocular Procedures ex Retina, Iris & Lens
43	2	Hyphema
44	2	Acute Major Eye Infections
45	2	Neurological Eye Disorders
46	2	Other Disorders of the Eye age >=18 w/ CC
47	2	Other Disorders of the Eye age >=18 w/o CC
48	2	Other Disorders of the Eye age <18
49	3	Major Head & Neck Procedures
50	3	Sialoadenectomy
51	3	Salivary Gland Procedures ex Sialoadenectomy
52	3	Cleft Lip & Palate Repair
53	3	Sinus & Mastoid Procedures age >=18
54	3	Sinus & Mastoid Procedures age <18
55	3	Miscellaneous Ear, Nose & Throat Procedures
56	3	Rhinoplasty
57	3	T & A Procedure ex Tonsillectomy &/or Adenoidectomy only age >17
58	3	T & A Procedure ex Tonsellectomy &/or Adenoidectomy only age <=17
59	3	Tonsillectomy &/or Adenoidectomy only age >17
60	3	Tonsillectomy &/or Adenoidectomy only age <=17
61	3	Myringotomy age >17
62	3	Myringotomy age <=17
63	3	Other Ear, Nose & Throat O.R. Procedures
64	3	Ear, Nose & Throat Malignancy
65	3	Dysequilibrium
66	3	Epistaxis
67	3	Epiglottitis
68	3	Otitis Media & URI age >=70 &/or CC
69	3	Otitis Media & URI age 18-69 w/o CC
70	3	Otitis Media & URI age <18
71	3	Laryngotracheitis
72	3	Nasal Trauma & Deformity
73	3	Other Ear, Nose & Throat Diagnoses age >=18
74	3	Other Ear, Nose & Throat Diagnoses age <18
75	4	Major Chest Procedures
76	4	O.R. Proc on the Respiratory System ex Major Chest w/ CC
77	4	O.R. Proc on the Respiratory System ex Major Chest w/o CC
78	4	Pulmonary Embolism
79	4	Respiratory Infections & Inflammations age >=70 &/or CC
80	4	Respiratory Infections & Inflammations age 18-69 w/o CC
81	4	Respiratory Infections & Inflammations age <18
82	4	Respiratory Neoplasms
83	4	Major Chest Trauma age >=70 &/or CC
84	4	Major Chest Trauma age <70 w/o CC
85	4	Pleural Effusion age >=70 &/or CC
86	4	Pleural Effusion age <70 w/o CC
87	4	Pulmonary Edema & Respiratory Failure
88	4	Chronic Obstructive Pulmonary Disease
89	4	Simple Pneumonia & Pleurisy age >=70 &/or CC
90	4	Simple Pneumonia & Pleurisy age 18-69 w/o CC
91	4	Simple Pneumonia & Pleurisy age <18
92	4	Interstitial Lung Disease age >=70 &/or CC
93	4	Interstitial Lung Disease age <70 w/o CC
94	4	Pneumothorax age >=70 &/or CC
95	4	Pneumothorax age <70 w/o CC
96	4	Bronchitis & Asthma age >=70 &/or CC
97	4	Bronchitis & Asthma age 18-69 w/o CC
98	4	Bronchitis & Asthma age <18
99	4	Respiratory Signs & Symptoms age >=70 &/or CC
100	4	Respiratory Signs & Symptoms age <70 w/o CC
101	4	Other Respiratory Diagnoses age >=70 &/or CC
102	4	Other Respiratory Diagnoses age <70
103	5	Heart Transplant
104	5	Cardiac Valve w/ Pump & w/ Cardiac Cath
105	5	Cardiac Valve w/ Pump & w/o Cardiac Cath
106	5	Coronary Bypass w/ Cardiac Cath

DRGs Used in VA Hospitals

DRG	MDC	DRGNAME
107	5	Coronary Bypass w/o Cardiac Cath
108	5	Cardiothoracic Procedures ex Valve & Coronary Bypass, w/ Pump
109	5	Cardiothoracic Procedures w/o Pump
110	5	Major Reconstructive Vascular Procedures age >=70 &/or CC
111	5	Major Reconstructive Vascular Procedures age <70 w/o CC
112	5	Vascular Procedures ex Major Reconstruction
113	5	Amputation Procedures for Circulatory System Disorders ex Upper Limb & Toe
114	5	Upper Limb & Toe Amputation Procedures for Circulatory System
115	5	Permanent Cardiac Pacemaker Implant w/ AMI
116	5	Permanent Cardiac Pacemaker Implant w/o AMI, Heart Failure or Shock
117	5	Cardiac Pacemaker Replace & Revis ex Pulse Generator Replacement Only
118	5	Cardiac Pacemaker Pulse Generator Replacement
119	5	Vein Ligation & Stripping Procedure
120	5	Other O.R. Procedures on the Circulatory System
121	5	Circulatory Disorders w/ AMI & C.V. Comp. Discharged Alive
122	5	Circulatory Disorders w/ AMI w/o C.V. Comp. Discharged Alive
123	5	Circulatory Disorders w/ AMI, Expired
124	5	Circulatory Disorders ex AMI, w/ Cardiac Cath & Complex Diagnosis
125	5	Circulatory Disorders ex AMI, w/ Cardiac Cath w/o Complex Diagnosis
126	5	Acute & Subacute Endocarditis
127	5	Heart Failure & Shock
128	5	Deep Vein Thrombophlebitis
129	5	Cardiac Arrest
130	5	Peripheral Vascular Disorders age >=70 &/or CC
131	5	Peripheral Vascular Disorders age <70 w/o CC
132	5	Atherosclerosis age >=70 &/or CC
133	5	Atherosclerosis age <70 w/o CC
134	5	Hypertension
135	5	Cardiac Congenital & Valvular Disorders age >=70 &/or CC
136	5	Cardiac Congenital & Valvular Disorders age 18-69 w/o CC
137	5	Cardiac Congenital & Valvular Disorders age <18
138	5	Cardiac Arrhythmia & Conduction Disorders age >=70 &/or CC
139	5	Cardiac Arrhythmia & Conduction Disorders age <70 &/or CC
140	5	Angina Pectoris
141	5	Syncope & Collapse age >=70 &/or CC
142	5	Syncope & Collapse age <70 w/o CC
143	5	Chest Pain
144	5	Other Circulatory Diagnoses w/ CC
145	5	Other Circulatory Diagnoses w/o CC
146	6	Rectal Resection Procedure age >=70 &/or CC
147	6	Rectal Resection Procedure age <70 w/o CC
148	6	Major Small & Large Bowel Procedures age >=70 &/or CC
149	6	Major Small & Large Bowel Procedures age <70 w/o CC
150	6	Peritoneal Adhesiolysis Procedure age >=70 &/or CC
151	6	Peritoneal Adhesiolysis Procedure age <70 w/o CC
152	6	Minor Small & Large Bowel Procedures age >=70 &/or CC
153	6	Minor Small & Large Bowel Procedures age <70 w/o CC
154	6	Stomach, Esophageal & Duodenal Procedures age >=70 &/or CC
155	6	Stomach, Esophageal & Duodenal Procedures age 18-69 w/o CC
156	6	Stomach, Esophageal & Duodenal Procedures age <18
157	6	Anal Procedures age >=70 &/or CC
158	6	Anal Procedures age <70 w/o CC
159	6	Hernia Procedures ex Inguinal & Femoral age >=70 &/or CC
160	6	Hernia Procedures ex Inguinal & Femoral age <70 w/o CC
161	6	Inguinal & Femoral Hernia Procedures age >=70 &or CC
162	6	Inguinal & Femoral Hernia Procedures age 18-69 w/o CC
163	6	Inguinal & Femoral Hernia Procedures age <18
164	6	Appendectomy w/ Complicated Principal Diagnosis age >=70 &/or CC
165	6	Appendectomy w/ Complicated Principal Diagnosis age <70 w/o CC
166	6	Appendectomy w/o Complicated Principal Diagnosis age >=70 w/o CC
167	6	Appendectomy w/o Complicated Principal Diagnosis age <70 w/o CC
168	6	Procedures on the Mouth age >=70 &/or CC
169	6	Procedures on the Mouth age <70 w/o CC
170	6	Other Digestive System Procedures age >=70 &/or CC
171	6	Other Digestive System Procedures age <70 w/o CC
172	6	Digestive Malignancy age >=70 &/or CC
173	6	Digestive Malignancy age <70 w/o CC
174	6	G.I. Hemorrhage age >=70 &/or CC
175	6	G.I. Hemorrhage age <70 w/o CC
176	6	Complicated Peptic Ulcer
177	6	Uncomplicated Peptic Ulcer >=70 &/or CC
178	6	Uncomplicated Peptic Ulcer <70 w/o CC
179	6	Inflammatory Bowel Disease
180	6	G.I. Obstruction age >=70 &/or CC
181	6	G.I. Obstruction age <70 w/o CC
182	6	Esophagitis, Gastroent & Misc Digest. Dis age >=70 &/or CC
183	6	Esophagitis, Gastroent & Misc Digest. Dis age 18-69 w/o CC
184	6	Esophagitis, Gastroent & Misc Digest. Dis age <18
185	6	Dental & Oral Dis. ex Extractions & Restorations age >17
186	6	Dental & Oral Dis. ex Extractions & Restorations age <=17
187	6	Dental Extractions & Restorations
188	6	Other Digestive System Diagnoses age >=70 &/or CC
189	6	Other Digestive System Diagnoses age 18-69 w/o CC
190	6	Other Digestive System Diagnoses age <18
191	7	Major Pancreas, Liver & Shunt Procedures
192	7	Minor Pancreas, Liver & Shunt Procedures
193	7	Biliary Tract Proc ex Total Cholecystectomy age >=70 &/or CC
194	7	Biliary Tract Proc ex Total Cholecystectomy age <70 w/o CC
195	7	Total Cholecystectomy w/ CDE age >=70 &/or CC
196	7	Total Cholecystectomy w/ CDE age <70 w/o CC
197	7	Total Cholecystectomy w/o CDE age >=70 &/or CC
198	7	Total Cholecystectomy w/o CDE age <70 w/o CC
199	7	Hepatobiliary Diagnostic Procedure for Malignancy
200	7	Hepatobiliary Diagnostic Procedure for Non-Malignancy
201	7	Other Hepatobiliary or Pancreas O.R. Procedures
202	7	Cirrhosis & Alcoholic Hepatitis
203	7	Malignancy of Hepatobiliary System or Pancreas
204	7	Disorders of Pancreas ex Malignancy
205	7	Disorders of Liver ex Malig, Cirr, Alc Hepa age >=70 &/or CC
206	7	Disorders of Liver ex Malig, Cirr, Alc Hepa age <70 w/o CC
207	7	Disorders of the Biliary Tract age >=70 &/or CC
208	7	Disorders of the Biliary Tract age <70 w/o CC
209	8	Major Joint Procedures
210	8	Hip & Femur Procedures ex Major Joint age >=70 &/or CC
211	8	Hip & Femur Procedures ex Major Joint age 18-69 w/o CC
212	8	Hip & Femur Procedures ex Major Joint age <18

DRGs Used in VA Hospitals

DRG	MDC	DRGNAME
213	8	Amputation Proc for Musculoskeletal System & Conn Tiss Disord.
214	8	Back & Neck Procedures age >=70 &/or CC
215	8	Back & Neck Procedures age <70 w/o CC
216	8	Biopsies of Musculoskeletal System & Connective Tissue
217	8	Wound Debridement & Skin Grafts ex Hand, for Musc Syst & Conn Tiss
218	8	Lower Extremity & Humerous Proc ex Hip, Foot, Femur age>=70 &/or CC
219	8	Lower Extremity & Humerous Proc ex Hip, Foot, Femur age 18-69 w/o CC
220	8	Lower Extremity & Humerous Proc ex Hip, Foot, Femur age <18
221	8	Knee Procedures age >=70 &/or CC
222	8	Knee Procedures age <70 w/o CC
223	8	Upper Extremity Proc ex Humerus & Hand age >=70 &/or CC
224	8	Upper Extremity Proc ex Humerus & Hand age <70 w/o CC
225	8	Foot Procedures
226	8	Soft Tissue Procedures age >=70 &/o CC
227	8	Soft Tissue Procedures age <70 w/o CC
228	8	Ganglion (Hand) Procedures
229	8	Hand Procedures ex Ganglion
230	8	Local Excision & Removal of Internal Fixation Devices of Hip & Femur
231	8	Local Excision & Removal of Internal Fixation Devices ex Hip & Femur
232	8	Arthroscopy
233	8	Other Musculoskelet Syst & Conn Tiss O.R. Proc age >=70 &/or CC
234	8	Other Musculoskelet Syst & Conn Tiss O.R. Proc age <70 w/o CC
235	8	Fractures of Femur
236	8	Fractures of Hip & Pelvis
237	8	Sprains, Strains & Dislocations of Hip, Pelvis & Thigh
238	8	Osteomyelitis
239	8	Pathological Fractures & Musculoskeletal & Conn Tiss Malign
240	8	Connective Tissue Disorders age >=70 &/or CC
241	8	Connective Tissue Disorders age <70 w/o CC
242	8	Septic Arthritis.
243	8	Medical Back Problems
244	8	Bone Diseases & Septic Arthropathy age >=70 &/or CC
245	8	Bone Diseases & Septic Arthropathy age <70 w/o CC
246	8	Non-Specific Arthropathies
247	8	Signs & Symptoms of Musculoskeletal System & Connective Tissue
248	8	Tendonitis, Myositis & Bursitis
249	8	Aftercare, Musculoskeletal System & Connective Tissue
250	8	Fx, Sprns, Strns & Disl of Forearm, Hand, Foot age >=70 &/or CC
251	8	Fx, Sprns, Strns & Disl of Forearm, Hand, Foot age 18-69 w/o CC
252	8	Fx, Sprns, Strns & Disl of Forearm, Hand, Foot age <18
253	8	Fx, Sprns, Strns & Disl of Uparm, Lowleg ex Foot age >=70 &/or CC
254	8	Fx, Sprns, Strns & Disl of Uparm, Lowleg ex Foot age 18-69 w/o CC
255	8	Fx, Sprns, Strns & Disl of Uparm, Lowleg ex Foot age <18
256	8	Other Diagnoses of Musculoskeletal System & Connective Tissue
257	9	Total Mastectomy for Malignancy age >=70 &/or CC
258	9	Total Mastectomy for Malignancy age <70 w/o CC
259	9	Subtotal Mastectomy for Malignancy age >=70 &/or CC
260	9	Subtotal Mastectomy for Malignancy age <70 w/o CC
261	9	Breast Proc for Non-Malignancy Except Biopsy & Local Excision
262	9	Breast Biopsy & Local Excision for Non-Malignancy
263	9	Skin Grafts for Skin Ulcer or Cellulitis age >=70 &/or CC
264	9	Skin Grafts for Skin Ulcer or Cellulitis age <70 w/o CC
265	9	Skin Grafts ex for Skin Ulcer or Cellulitis age >=70 &/or CC
266	9	Skin Grafts ex for Skin Ulcer or Cellulitis age <70 w/o CC
267	9	Perianal & Pilonidal Procedures
268	9	Skin, Subcutaneous Tissue & Breast Plastic Procedures
269	9	Other Skin, Subcut Tiss & Breast O.R. Proc age >=70 &/or CC
270	9	Other Skin, Subcut Tiss & Breast O.R. Proc age <70 w/o CC
271	9	Skin Ulcers
272	9	Major Skin Disorders age >=70 &/or CC
273	9	Major Skin Disorders age <70 w/o CC
274	9	Malignant Breast Disorders age >=70 &/or CC
275	9	Malignant Breast Disorders age <70 w/o CC
276	9	Non-Malignant Breast Disorders
277	9	Cellulitis age >=70 &/or CC
278	9	Cellulitis age 18-69 w/o CC
279	9	Cellulitis age <18
280	9	Trauma to the Skin, Subcut Tiss & Breast age >=70 &/or CC
281	9	Trauma to the Skin, Subcut Tiss & Breast age 18-69 w/o CC
282	9	Trauma to the Skin, Subcut Tiss & Breast age <18
283	9	Minor Skin Disorders age >=70 &/or CC
284	9	Minor Skin Disorders age <70 w/o CC
285	10	Amputation Procs for Endocrine, Nutritional & Metabolic Disorders
286	10	Adrenal & Pituitary Procedures
287	10	Skin Grafts & Wound Debridement for Endoc, Nutrit & Metab Disord
288	10	O.R. Procedures for Obesity
289	10	Parathyroid Procedures
290	10	Thyroid Procedures
291	10	Thyroglossal Procedures
292	10	Other Endocrine, Nutrit & Metab Disord O.R. Proc age >70 &/or CC
293	10	Other Endocrine, Nutrit & Metab Disord O.R. Proc age <70 w/o CC
294	10	Diabetes age >=36
295	10	Diabetes age <36 .
296	10	Nutritional & Misc Metabolic Disorders age >=70 &/or CC
297	10	Nutritional & Misc Metabolic Disorders age 18-69 w/o CC
298	10	Nutritional & Misc Metabolic Disorders age <18
299	10	Inborn Errors of Metabolism
300	10	Endocrine Disorders age >=70 &/or CC
301	10	Endocrine Disorders age <70 w/o CC
302	11	Kidney Transplant Procedure
303	11	Kidney, Ureter & Major Bladder Procedure for Neoplasms
304	11	Kidney, Ureter & Major Bladder Proc for Non-Malig age >=70 &/or CC
305	11	Kidney, Ureter & Major Bladder Proc for Non-Malig age <70 w/o CC
306	11	Prostatectomy age >=70 &/or CC
307	11	Prostatectomy age <70 w/o CC
308	11	Minor Bladder Procedures age >=70 &/or CC
309	11	Minor Bladder Procedures age <70 w/o CC
310	11	Transurethral Procedures age >=70 &/or CC
311	11	Transurethral Procedures age <70 w/o CC
312	11	Urethral Procedures age >=70 &/or CC
313	11	Urethral Procedures age 18-69 w/o CC
315	11	Other Kidney & Urinary Tract O.R. Procedures
316	11	Renal Failure
317	11	Admit for Dialysis
318	11	Kidney & Urinary Tract Neoplasms age >=70 &/or CC
319	11	Kidney & Urinary Tract Neoplasms age <70 w/o CC

DRGs Used in VA Hospitals

DRG	MDC	DRGNAME
320	11	Kidney & Urinary Tract Infections age >=70 &/or CC
321	11	Kidney & Urinary Tract Infections age 18-69 w/o CC
322	11	Kidney & Urinary Tract Infections age <18
323	11	Urinary Stones age >=70 &/or CC
324	11	Urinary Stones age <70 w/o CC
325	11	Kidney & Urinary Tract Signs & Symptoms age >=70 &/or CC
326	11	Kidney & Urinary Tract Signs & Symptoms age 18-69 w/o CC
327	11	Kidney & Urinary Tract Signs & Symptoms age <18 w/o CC
328	11	Urethral Stricture age >=70 &/or CC
329	11	Urethral Stricture age 18-69 w/o CC
330	11	Urethral Stricture age <18 w/o CC
331	11	Other Kidney & Urinary Tract Diagnoses age >=70 &/or CC
332	11	Other Kidney & Urinary Tract Diagnoses age 18-69 w/o CC
333	11	Other Kidney & Urinary Tract Diagnoses age <18
334	12	Major Male Pelvic Procedures w/ CC
335	12	Major Male Pelvic Procedures w/o CC
336	12	Transurethral Prostatectomy age >=70 &/or c
337	12	Transurethral Prostatectomy age <70 w/o CC
338	12	Testes Procedures for Malignancy
339	12	Testes Procedures Non-Malignant age >=18
340	12	Testes Procedures Non-Malignant age <18
341	12	Penis Procedures
342	12	Circumcision age >=18
343	12	Circumcision age <18
344	12	Other Male Reproductive System O.R. Proc for Malignancy
345	12	Other Male Reproductive System O.R. Proc ex for Malignancy
346	12	Malignancy of Male Reproductive System age >=70 &/or CC
347	12	Malignancy of Male Reproductive System age <70 w/o CC
348	12	Benign Prostatic Hypertrophy age >=70 &/or CC
349	12	Benign Prostatic Hypertrophy age <70 w/o CC
350	12	Inflammation of the Male Reproductive System
351	12	Sterilization Male
352	12	Other Male Reproductive System Diagnoses
353	13	Pelvic Evisceration, Radical Hysterectomy & Vulvectomy
354	13	Non-Radical Hysterectomy age >=70 &/or CC
355	13	Non-Radical Hysterectomy age <70 w/o CC
356	13	Female Reproductive System Reconstructive Procedures
357	13	Uterus & Adenexa Procedures for Malignancy
358	13	Uterus & Adenexa Proc for Non-Malignancy ex Tubal Interruption
359	13	Tubal Interruption for Non-Malignancy
360	13	Vagina, Cervix & Vulva Procedures
361	13	Laparoscopy & Endoscopy (Female) ex Tubal Interruption
362	13	Laparoscopic Tubal Interruption
363	13	D & C, Conization & Radio-Implant for Malignancy
364	13	D & C, Conization ex for Malignancy
365	13	Other Female Reproductive System O.R. Procedures
366	13	Malignancy of Female Reproductive System age >=70 &/or CC
367	13	Malignancy of Female Reproductive System age <70 w/o CC
368	13	Infections of Female Reproductive System
369	13	Menstrual & Other Female Reproductive System Disorders
370	14	Cesarean Section w/ CC
371	14	Cesarean Section w/o CC
372	14	Vaginal Delivery w/ Complicating Diagnoses
373	14	Vaginal Delivery w/o Complicating Diagnoses
374	14	Vaginal Delivery w/ Sterilization &/or D & C
375	14	Vaginal Delivery w/ O.R. Procedure ex Sterilization &/or D & C
376	14	Postpartum & Post Abortion Diagnoses w/o O.R. Procedure
377	14	Postpartum & Post Abortion Diagnoses w/ O.R. Procedure
378	14	Ectopic Pregnancy
379	14	Threatened Abortion
380	14	Abortion w/o D & C
381	14	Abortion w/ D & C
382	14	False Labor
383	14	Other Antepartum Diagnoses w/ Medical Complications
384	14	Other Antepartum Diagnoses w/o Medical Complications
385	15	Neonates, Died or Transferred
386	15	Neonate Extreme Immaturity or Respiratory Distress Syndrome
387	15	Prematurity w/ Major Problems
388	15	Prematurity w/o Major Problems
389	15	Full Term Neonate w/ Major Problems
390	15	Neonates w/ Other Significant Problems
391	15	Normal Newborn
392	16	Splenectomy age >=18
393	16	Splenectomy age <18
394	16	Other O.R. Procedures of the Blood & Blood Forming Organs
395	16	Red Blood Cell Disorders age >=18
396	16	Red Blood Cell Disorders age <18
397	16	Coagulation Disorders
398	16	Reticuloendothelial & Immunity Disorders age >=70 &/or CC
399	16	Reticuloendothelial & Immunity Disorders age <70 w/o CC
400	17	Lymphoma or Leukemia w/ Major O.R. Procedure
401	17	Lymphoma or Leukemia w/ Minor O.R. Procedure age >=70 &/or CC
402	17	Lymphoma or Leukemia w/ Minor O.R. Procedure age <70 w/o CC
403	17	Lymphoma or Leukemia age >=70 &/or CC
404	17	Lymphoma or Leukemia age 18-69 w/o CC
405	17	Lymphoma or Leukemia age <18
406	17	Myeloprolif Disord or Poorly Diff Neoplasm w/ Major O.R. Proc & CC
407	17	Myeloprolif Disord or Poorly Diff Neopl w/ Major O.R. Proc w/o CC
408	17	Myeloprolif Disord or Poorly Diff Neopl w/ Minor O.R. Proc
409	17	Radiotherapy
410	17	Chemotherapy
411	17	History of Malignancy w/o Endoscopy
412	17	History of Malignancy w/ Endoscopy
413	17	Other Myeloprolif Disord or Poorly Diff Neopl Dx age >=70 &/or CC
414	17	Other Myeloprolif Disord or Poorly Diff Neopl Dx age <70 w/o CC
415	18	O.R. Procedure for Infectious & Parasitic Diseases
416	18	Septicemia age >=18
417	18	Septicemia age <18
418	18	Postoperative & Post-Traumatic Infections
419	18	Fever of Unknown Origin age >=70 &/or CC
420	18	Fever of Unknown Origin age 18-69 w/o CC
421	18	Viral Illness age >=18
422	18	Viral Illness age <18
423	18	Other Infectious & Parasitic Diseases Diagnoses
424	19	O.R. Procedures w/ Principal Diagnosis of Mental Illness
425	19	Acute Adjust Reaction & Disturbances of Psychosocial Dysfunction

DRGs Used in VA Hospitals

DRG	MDC	DRGNAME
426	19	Depressive Neuroses
427	19	Neuroses ex Depressive
428	19	Disorders of Personality & Impulse Control
429	19	Organic Disturbances & Mental Retardation
430	19	Psychoses
431	19	Childhood Mental Disorders
432	19	Other Diagnoses of Mental Disorders
433	20	Substance Use & Substance Induced Organic Mental Disorders
434	20	Drug Dependence
435	20	Drug Use ex Dependence
436	20	Alcohol Dependence
437	20	Alcohol Use ex Dependence
438	20	Alcohol & Substance Induced Organic Mental Syndrome
439	21	Skin Grafts for Injuries
440	21	Wound Debridement for Injuries
441	21	Hand Procedures for Injuries
442	21	Other O.R. Procedures for Injuries age >=70 &/or CC
443	21	Other O.R. Procedures for Injuries age <70 w/o CC
444	21	Multiple Trauma age >=70 &/or CC
445	21	Multiple Trauma age 18-69 w/o CC
446	21	Multiple Trauma age <18
447	21	Allergic Reactions age >=18
448	21	Allergic Reactions age <18
449	21	Toxic Effects of Drugs age >=70 &/or CC
450	21	Toxic Effects of Drugs age 18-69 w/o CC
451	21	Toxic Effects of Drugs age <18
452	21	Complications of Treatment age >=70 &/or CC
453	21	Complications of Treatment age <70 w/o CC
454	21	Other Injuries, Poisonings & Toxic Effects Diagnoses age >=70 &/or CC
455	21	Other Injuries, Poisonings & Toxic Effects Diagnoses age <70 w/o CC
457	22	Extensive Burns
458	22	Non-Extensive Burns w/ Skin Grafts
459	22	Non-Extensive Burns w/ Wound Debridement & Other O.R. Procs for Burns
460	22	Non-Extensive Burns w/o O.R Event
461	23	O.R. Proc w/ Diagnoses of Other Contact w/ Health Svcs
462	23	Rehabilitation
463	23	Signs & Symptoms w/ CC
464	23	Signs & Symptoms w/o CC
465	23	Aftercare w/ History of Malignancy as Secondary Diagnosis
466	23	Aftercare w/o History of Malignancy as Secondary Diagnosis
467	23	Other Factors Influencing Health Status
468	99	Unrelated O.R. Procedure
469	99	Invalid Principal Diagnosis
470	99	Ungroupable

COMPARATIVE COST OF INPATIENT HOSPITAL CARE: THE VETERANS ADMINISTRATION AND THE PRIVATE SECTOR

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EXECUTIVE SUMMARY

This report compares one aspect of the cost of health care in FY 1984 in Veterans Administration medical centers with the costs of similar care in non-VA facilities. The VA is a totally integrated system, providing a full range of services--acute, intermediate, nursing home, outpatient, and hospital-based home care. This analysis compares only the costs of care provided in VA acute-care facilities with the costs in acute-care non-VA facilities. No effort has been made to compare outpatient, nursing home, or other types of care.

Previous cost comparisons have been criticized because of lack of comparability in both data and patient mix. The development of prospective payment based on diagnosis related groups (DRGs) by the Department of Health and Human Services, Health Care Financing Administration (HCFA) for Medicare patients and the adoption of DRGs for resource allocation purposes by the VA Department of Medicine and Surgery provides a methodology for calculating a VA cost per case which largely overcomes previous objections.

The methodology employed in these analyses was to develop a VA average cost per discharged case from information in the VA's cost reporting system (RCS 10-0141) and the patient treatment file (PTF). The VA average cost per case was calculated at three levels of aggregation--DRG, bed service (i.e., medicine, surgery, and psychiatry sections), and appropriate state, regional, or national geographic level. The non-VA comparative cost was calculated by applying costs, reimbursements, and/or charges per DRG from non-VA sources to VA discharges. Thus, the non-VA cost was based on VA patient mix, excluding insofar as possible types of patients not normally treated in VA hospitals.

The basic VA cost comprised all factors attributable to patient care: direct and education expenditures, indirect expenditures, and resident stipends. Physician salaries were subtracted to conform to the private sector which treats physician fees separately from hospital costs. Costs associated with census patient care, research, contracts, and beneficiary travel are also excluded. The resulting dollar amount was increased, in most instances, by 11.4 percent, the estimated cost of capital and other unfunded VA costs. Factors included in the 11.4 percent adjustment are shown in Appendix C.

Wherever possible, the VA cost was adjusted to include or exclude cost elements so as to achieve maximum comparability with non-VA cost data. These adjustments primarily involved unusually long lengths of stay (outliers) and their associated costs, resident stipends, and capital costs. A table showing the cost elements included in each analysis is presented in Appendix A.

A special analysis of costs for treating psychiatric discharges takes into account the VA's unique differences in psychiatric care as compared to the private sector (see Appendix E). When DRG trim point discharges are examined, the disparity of cost or reimbursement differences is reduced.

Suitable data were obtained from Medicare (HCFA) for both prospective payment and waivered facilities, the State of Utah Medicaid program, the State of Maryland Cost Review Commission, a major teaching hospital in the Northeast, and the California Health Facilities Commission. Detailed results of the analyses are displayed in Tables 1-18. A summary of the results follows.

	NON-VA CHARGE	NON-VA REIMBURSEMENT	NON-VA COST	VA COST
*HCFA (PPS)	$3,685	$2,769	-----	$3,262
*HCFA (waivered)	$4,663	$2,970	-----	$3,819
**Utah Medicaid	$3,802	$2,817	-----	$4,025
Maryland	$4,865	-----	$3,695	$3,680
NE teaching hosp.	-----	-----	$4,623	$3,728
California	$5,554	-----	-----	$4,539

In general, it cannot be definitively asserted that VA acute care is more or less costly than acute care in non-VA facilities for the same case mix. With the exception of Utah Medicaid, however, VA costs are substantially less than hospitals are charging for their services to similar patients. In the two instances where actual cost data were obtainable, VA costs are less or approximately the same. The conclusion is that the cost of acute care in VA medical centers is consistent with, and comparable to, the estimated cost of acute care in non-VA facilities for the same mix of patients.

*Reimbursement amounts do not include the 1984 Medicare deductible of $356 or copayments paid by the patient, his or her family, or other third-party payors. Therefore, Medicare reimbursements are not equivalent to costs. In 1984, Medicare reimbursed approximately 71 percent of charges by prospective payment facilities and 65 percent of charges by waivered facilities.

**Utah Medicaid reimbursed approximately 73 percent of hospital charges in 1984.

INTRODUCTION

This study was executed in response to a July 1984 request from the chairman of the White House Working Group on Health Policy and Economics. The Veterans Administration was asked to ascertain the availability of data for comparing the cost of acute care among VA hospitals with the cost of similar care in other hospitals, both public and private, using a diagnosis related group (DRG) methodology. The charge from the working group directed the Veterans Administration to address both Federal budget costs and total costs to society.

Precise comparisons between Veterans Administration health care costs and costs in other sectors are problematic. First, the VA cannot obtain completely comparable data from either the private or public sectors, although currently available data represent a substantial improvement over the past. Second, the objectives of VA health care differ from the objectives in the private sector. The private sector is necessarily concerned with growth, profitability, and cost containment. Under these imperatives, some private sector facilities may curtail or eliminate unprofitable programs and services. The VA, on the other hand, is mandated to provide comprehensive health care to the eligible population. As a vertically integrated system, the VA must maintain a full range of health care services. Achievement of these different objectives will generate differences in costs.

An important difference between VA health care and the private sector is the presence of a significant long-term psychiatric patient population. Approximately 45 to 50 VA facilities treat types of chronic psychiatric patients ordinarily found only in state and county institutions. In 35 to 40 of these VA medical centers, psychiatric workload accounts for 50 percent or more of the total workload. In private sector acute general medical and surgical hospitals, psychiatric care is curtailed by insurance coverage which is purposefully more limited than coverage for medical and surgical conditions. Whereas an individual's insurance will pay for an unlimited number of hospitalizations for diabetes, the same insurance coverage will limit the number of psychiatric hospital days, both annually and over the life of the policy. When benefits are exhausted, the insured is either transferred to a state or county hospital, sent to a private long-term psychiatric hospital at his or her own expense, or "deinstitutionalized." The VA psychiatry service is caring for both acute and chronic patients, often in the same environment, and is therefore not readily comparable to either public or private facilities. Furthermore, psychiatric inpatients in VA medical centers are provided a full range of medical services, e.g., dental care or necessary surgery, concurrently with their psychiatric treatment.

Previous efforts to carry out this type of analysis have been seriously hampered by the lack of suitable data to estimate comparable VA and non-VA costs per case and of an adequate method of comparing patient populations. An analysis completed in 1981 (revised in 1982) by the Health System Information Service, Office of Program Analysis and Development in the Department of Medicine and Surgery developed estimates of the cost of an episode of medicine and surgery acute care in a Veterans Administration medical center as opposed to the cost in community hospitals. The cost estimates were based on multiplying an estimated average length of stay for all patients by an average system-wide per diem. Comparable estimates were developed for community hospitals based on cost data from the American Hospital Association's (AHA) 1980 Annual Survey of Hospitals. Major criticisms of this approach cited incomparabilities in the data and differences in patient mix between the VA and the private sector.

Recent developments in the field of health care financing have served to mitigate substantially the problem of incomparable patient mix. Since completion of the 1981 cost comparison study, researchers have refined the diagnosis related group (DRG) patient classification methodology. Under the DRG system, each patient discharge is classified into one of 470 categories. Assignment to a category depends on diagnosis and other factors such as age, the presence or absence of complications and comorbidities, and whether or not surgery was performed. It has been demonstrated that patients in each group require similar amounts of resources in their treatment.

While DRG patient classification provides the best available tool for comparing patient types and explaining variation in resource utilization, it is not perfect. Some analysts believe that severity of illness indicators or disease staging concepts will explain variance in resource consumption above and beyond DRGs. However, neither the data nor the technology is currently available to incorporate severity of illness cost differences in a study of the scope of the current one.

With respect to comparable patient mix, the DRG system may not account for fundamental differences in the composition of patient populations as a whole. Examples of these fundamental differences abound. The majority of Medicare patients are elderly. The Medicaid data used in this study reflect high proportions of females and infants, presumably from a poverty population. VA patients are preponderantly male and also from low socio-economic groups, but with a broader age distribution than Medicare patients. The available data do not permit assessment of the effects of patient age and sex differences on costs of care of VA patients compared with other patients.

In 1983, the Health Care Financing Administration (HCFA) adopted DRGs as the basis for its prospective payment system (PPS). Under prospective payment, hospitals are reimbursed a fixed sum for each episode of care depending on the discharge DRG. As a consequence, hospitals are required to maintain discharge abstracts with DRG information. Increasingly state rate commissions and health departments are following this practice. These abstracts, along with hospital charges, payor reimbursement and, in two instances, actual cost estimates, furnish data from which non-VA costs per case[1] can be approximated after taking out case-mix differences.

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[1] The term cost is frequently used in the text in a generic sense. The author recognizes that the usage is imprecise. However, it should be clear from the context whether the referent is charges, and/or reimbursements, or actual cost estimates.

In 1984, the Veterans Administration's Department of Medicine and Surgery adopted a DRG-based methodology for acute care resource allocation. By combining cost information from the Medical Care Distribution Accounts (RCS 10-0141) with clinical information from the Patient Treatment File (PTF), a cost per case can be calculated for a given category of VA patient, and an overall cost per case that is sensitive to patient mix differences can be derived. As in the private sector, each VA discharge is now assigned a DRG classification. In the VA, DRG assignment depends upon the primary diagnosis, the condition that accounts for the greatest portion of treatment and length of stay. A brief description of the resource allocation methodology is presented in the next section.

In order to adequately describe the VA system, comparisons were made at the VA system-wide level, by DRG, and by bed section. Administratively, VA facilities are divided into medicine, surgery, and psychiatry bed sections based generally on the concentration of types of patients treated. However, it should be noted that a discharge from a particular bed section may be assigned a DRG seemingly more appropriate to another bed section. Such inconsistencies often occur when a patient requires more than one type of treatment. For example, a patient admitted to a psychiatry bed section to be treated for schizophrenia may ultimately be transferred to a medical bed section for treatment of cardiopulmonary disease. If the patient is then discharged from the medical bed section, that bed section receives credit for the discharge and the workload, even though the primary diagnosis may dictate a psychiatric DRG classification.

The objective of this analysis was to develop cost figures that would allow comparison of the average cost of treating an acute-care inpatient in the VA system to the average cost of treating a similar patient in a non-VA facility. This study does not address issues such as quality of care or the feasibility of treating VA patients in private-sector facilities. These are broad policy issues beyond the scope of this analysis.

THE METHODOLOGY

Two problems had to be resolved in order to calculate comparative costs. The first was to establish similarity of patient mix. This problem was resolved by applying non-VA cost, reimbursement, and/or charge data only to VA discharges. By this means, types of patients not normally treated in VA medical centers were largely eliminated in computing the non-VA average cost per discharge.

The second problem stemmed from the lack of a VA "patient bill." In non-VA sectors, an average cost per case is calculated by aggregating costs per DRG discharge and dividing by the total number of discharges per DRG. Achieving VA cost per case estimates that would be comparable depended upon distributing costs aggregated and reported at the medicine, surgery, and psychiatry bed service levels across patient types. The VA does not maintain a comprehensive information system that includes both clinical and demographic characteristics of patients and the costs of their health care. Thus, individual patient characteristics can only be linked to an average for the bed service rather than to the cost of individual care.

In estimating the VA cost per case for comparative purposes, concepts and techniques developed in devising the VA's resource allocation system were utilized. To fund patient care in the VA on a per person or per discharge basis, a "bill" had to be approximated. Patient characteristics reported in the Patient Treatment File (PTF), a patient-based hospital discharge abstract system, had to be joined to cost of care data from the Medical Care Distribution Accounts (RCS 10-0141), a cost center based information system, to obtain the estimated cost of treating an individual patient.

Because the variation in cost of treating patients in a VA hospital or bed service is unknown, several assumptions had to be made in order to estimate per patient or per discharge costs of care. (1) The "average" cost of care per patient in a bed service is an adequate, fair, or reasonable representation of the cost of care of individual patients in that bed service. (2) Variation around the "average cost of care" can be measured or simulated by using patient care characteristics that are sensitive to, or supposed to measure, variations in patient care resource requirements and, therefore, cost.

Patient care requirements were approximated by proxy measures, such as relative values or weights based on some patient mix classification. These relative values or weights were derived from cost studies in other inpatient environments and evaluated for applicability to the VA environment. The evaluation was based on whether the relative values or weights adequately described variation in the cost of patient care in the VA.

For VA resource allocation purposes, the diagnosis related group (DRG) patient classification system was adopted. A relative value or number of weights was assigned to each DRG discharge using the New Jersey DRG pricing system. In the VA, these weights are referred to as weighted work units. To arrive at the average direct and education costs per discharge at the bed service level, the number of weighted work units per DRG was multiplied by the number of discharges per DRG within a bed service and summed to the bed service administrative level. The total cost at the bed service administrative level as reported in the RCS 10-0141 was divided by the total number of weighted work units to obtain a unit cost. The unit cost was then multiplied by the average number of weighted work units per discharge within that bed service. Calculation of the system-wide average direct and education cost per case utilized the same procedure except that summation was taken to the system level.

The foregoing description applies primarily to the direct or "hands on" costs of patient care. A similar process of disaggregation and reaggregation was employed in calculating the indirect portion of the total cost. However, the indirect unit cost was based on bed days of care rather than on weighted work units because these costs, which include items such as building maintenance, laundry, and supplies, were not considered to vary according to patient condition as much as direct costs.

Except for one-day-stays, all discharges that fall within the DRG trim points for lengths of stay receive credit for the average dollar amount for resource allocation purposes. In order to encourage appropriate use of outpatient care as an alternative to inpatient admissions, the number of weighted work units for one-day-stays have been discounted. The effect of this practice on the VA estimated cost per case is to increase the dollar value of the weighted work unit. Consequently, the VA average cost per case shown in Tables 1-18 is actually overstated by approximately 6 percent. This VA pricing policy is not followed by HCFA, which reimburses at the full amount for any discharge that can be classified into a DRG.

Discharges with lengths of stay beyond the high trim point receive the average dollar amount plus a per diem for the additional days, referred to as outlier bed days of care. The trim points are fixed so as to include approximately 96 percent of discharges for each medical and surgical DRG and approximately 83 percent of discharges for psychiatry. The trim points for psychiatric patients were lowered for policy reasons to restrict the outflow of money to medicine and surgery under resource allocation. In the VA, high cost outliers are linked to length of stay outliers, and adjustments are made to the number of weighted work units credited.

For purposes of cost comparison, the VA comparative cost was calculated to include direct expenses, which include the cost of direct medical education, indirect expenses, resident stipends, and an 11.4 percent adjustment for capital (unfunded) expense. Physician salaries were subtracted because physician fees are treated separately from hospital costs in the private sector. Costs associated with census patient care, research, contracts, and beneficiary travel are also excluded. The basic cost was adjusted insofar as possible to reflect the components included or excluded from the comparative data. The principal differences involved the treatment of outliers, capital costs, and stipends. A table showing the VA cost components included in each analysis is provided in Appendix A.

The VA comparative cost per case accounts for all 1984 discharges covered by DRG resource allocation and all 1984 bed days of care associated with those discharges. More detailed discussions of the calculations and the 11.4 percent unfunded expense adjustment are found in Appendix B and Appendix C.

Because of dissimilarities in the VA and non-VA psychiatric patient populations and because some psychiatric patients are discharged from medicine and surgery bed sections, a separate analysis was performed on psychiatric DRG discharges. Outlier bed days of care and weighted work units were omitted from the length of stay and cost calculations in order to capture that portion of a VA episode of care corresponding more closely to a non-VA episode of care in an acute general hospital. The results are presented in Appendix E.

After calculating the VA cost per case, the DRG cost, charge, and/or reimbursement data from non-VA sources were applied to VA discharges and aggregated to the appropriate level. Thus, the non-VA cost per case at any level is based solely on the VA case mix. With the Medicare and Utah Medicaid data, the results show what non-VA hospitals would charge to Medicare and Medicaid patients and the amount these payors would reimburse for treating VA patients. The California analysis reflects only California charges. The Maryland analysis includes both Maryland charges and charges converted to costs, while the Northeast teaching hospital data are based on actual costs.

THE DATA [2]

In order to compare the VA's costs with non-VA sectors, data were sought from many sources. In most cases, actual cost data from outside sources were unobtainable. Major exceptions were the State of Maryland and the data from a large teaching hospital in the Northeast. The remaining data bases consisted of third-party reimbursements and/or hospital charges per DRG. A major assumption was that these charges and reimbursements bracket the true cost of care and provide a reasonable means of approximating the non-VA costs of treating a patient mix similar to that of the VA.

Other problems arose because (1) many states have not yet adopted DRG-based reimbursement systems for their Medicaid patients (e.g., Colorado); (2) complete records are not maintained for all diagnoses (e.g., Virginia); (3) requirements of confidentiality have caused lengthy delays in making data public (e.g., New York State); and (5) a number of states planning to institute DRG-based reimbursement encountered delays in implementation (e.g., Michigan). After an in-depth canvass of state health departments and rate commissions, suitable data bases were obtained from the Health Care Financing Administration (HCFA), the Health Services Cost Review Commission of the State of Maryland, the State of Utah Department of Health, a major teaching hospital in the Northeast, and the California Health Facilities Commission. These comparison groups maintain DRG-based data, although Maryland is a waivered state, i.e., exempt from Medicare's prospective reimbursement requirements.

Health Care Financing Administration. The data obtained from HCFA included average hospital charges billed to Medicare patients and average Medicare reimbursements by DRG for both prospective payment and non-prospective payment (waivered) facilities. Average charges were calculated by dividing the sum of all 1984 hospital bills submitted to Medicare for each DRG by the total number of bills submitted for each DRG. Medicare's average reimbursements to hospitals were calculated by dividing the sum of all 1984 payments for each DRG by the total number of bills for each DRG. For example, for DRG 1 under the prospective payment system, the average hospital bill was $293,603,000/20,665 = $14,208 while the average reimbursement by Medicare was $191,022,000/20,665 = $9,244. The availability of separate schedules of charges and reimbursements for prospective and non-prospective payment facilities provided the opportunity to compare both systems. These data reflected only national averages for 1984. Breakdowns by state, region, or individual facility were not obtainable.

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[2] Unless otherwise noted, data specifications and definitions were obtained from correspondence or personal communications with providers.

Medicare's prospective payment system (PPS), like the VA's allocation methodology, sets a predetermined specific reimbursement rate for each discharge. Unlike the VA, HCFA does not maintain separate reimbursement schedules for teaching and non-teaching hospitals. HCFA's rates are adjusted to reflect rural-urban differences and area hospital wage differentials. Payments are expected to cover all allowable inpatient operating costs other than Part B physician services and deductibles and copayments. Adjustments are made on a case by case basis for unusually long lengths of stay or unusually expensive cases (outliers). Capital costs continue to be reimbursed on a "reasonable cost" basis. Both capital costs and the indirect costs of medical education are added to the annual payment to facilities in a lump sum and are not included in the DRG reimbursement. Resident stipends and the estimated cost of capital were, therefore, excluded from the VA cost per case estimate in this comparison.[3]

HCFA has exempted short-term acute care hospitals in four states, Maryland, New York, New Jersey, and Massachusetts, and certain other categories of hospitals, e.g., children's hospitals, rehabilitation hospitals, and some types of psychiatric hospitals, from its prospective payment system. Hospitals in the four waivered states were exempted because they participate in state-wide cost control programs. The other types of hospitals are excluded because they are organized to treat conditions not ordinarily found in short-term acute care facilities. They therefore provide different services.[4] Reimbursements to these waivered facilities are based on negotiated interim rates which include the pass through amounts for capital costs and education. These costs were included in the VA cost for comparative purposes.

It is important to note that HCFA's reimbursement schedule does not include the deductible, $356 in 1984, or copayments paid by the patient, his or her family, and/or other third-party payors. HCFA reimbursements, therefore, understate the cost of treating Medicare patients, and they are not equivalent to VA costs. Because of the lack of appropriate data, no adjustments to HCFA reimbursements could be made to reflect these additional payments. While not costs to the Federal government, they are, nevertheless, part of the cost of health care which must be paid by someone or written off. In 1984, HCFA reimbursed 70.9 percent of charges billed by prospective payment facilities and 65.0 percent of charges billed by waivered facilities.

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[3] 48 FR 39761, 39776-39778

[4] 48 FR 39755, 39760

Utah Medicaid. A schedule of charges and reimbursements was obtained from the State of Utah Department of Health for its Medicaid patients. Utah's reimbursements are negotiated with providers and, in FY 1984, were calculated as follows:

$1,935 x the HCFA DRG weight for ten months
$2,035 x the HCFA DRG weight for two months

Approximately 11.8 percent of Utah's reimbursement consists of pass throughs of education costs, capital costs, and return on capital. Outlier days of care and high cost outliers are included in the DRG reported reimbursements. The VA comparative cost estimate, therefore, included resident stipends, outliers, and capital costs. Utah does not maintain separate schedules of charges and reimbursments for teaching and nonteaching hospitals.

In 1984, Utah Medicaid reimbursed approximately 73 percent of billed charges. Reported reimbursements are net of other third-party payments. According to the Acting Director of the Division of Health Care Financing, these average approximately 4 percent of the total. The reimbursement amounts reported in the analysis were inflated by 4 percent to adjust for these additional payments.

Maryland Cost Review Commission. Maryland charge and cost data were obtained from the Information Service Center (ISC), a nonprofit organization established by the Health Services Cost Review Commission (HSCRC) in order to make its data available at a reasonable cost to hospitals and other users. The Length of Stay and Charge Report used in this analysis displays discharge abstract data from all 54 acute general hospitals in Maryland. Charges and estimated costs were reported as state-wide averages per DRG for 1984 and, in addition, were broken down by three levels of teaching affiliation. This breakdown is comparable to the VA's three levels of supplementation used in 1984 and meant that Maryland costs and charges could be differentiated for Maryland VA medical centers.

The Length of Stay and Charge Report is based on the number of cases with usable data rather than the total number of cases. Outlier cases with charges of 0 or greater than $100,000 or lengths of stay greater than 120 days are excluded. The VA estimate in this comparison, therefore, excludes that portion of the cost of any discharge associated with unusual lengths of stay. Maryland does, however, include capital costs and the costs of medical education, and these were retained in the VA calculation.

Northeast Teaching Hospital Data. These cost data were furnished by a major teaching hospital in the Northeast. Cost estimates were calculated specifically for this analysis in the office of the hospital administrator. They were designed, to the extent possible, to provide comparability with the method of calculating VA costs. The cost per case includes direct and education expenses, indirect expenses, outliers, resident stipends, and capital costs, but not physician salaries. Since their cost estimates were based on 1985 dollars, a 4.1 percent deflator was applied to convert to 1984 dollars.

California Health Facilities Commission. The California charge data summarize all patient bills for 1983 aggregated to the DRG level. All potential payors are included, and valid records must have been assigned a valid payor code. Only hospital charges were available. The charges were inflated to 1984 dollars.

The Veterans Administration. The VA data were obtained from two sources, the Patient Treatment File (PTF) and the Report of Medical Care Distribution Accounts (RCS 10-0141) for FY 1984. These are the same data used to develop the VA acute care resource allocation models and target allowances. The PTF furnishes information on each patient discharged from a VA acute-care facility. This document is the source for data on lengths of stay, numbers and types of treatment, and diagnoses. Information from the PTF is used to classify each patient discharged into a diagnosis related group. The RCS 10-0141 is the method for distributing cost center costs among bed sections at the hospital level. It provided the basis for calculating unit costs—either per diem or workload—used to arrive at an estimated cost per discharge.

RESULTS OF THE ANALYSIS

Three tables are displayed for each geographic division and payment method analyzed. The first table in each set makes comparisons at the area level and by type of service (medicine, psychiatry, or surgery bed section). The second table displays comparative data for a sampling of 21 high discharge DRGs. These tables contain the following information: (1) total number of VA discharges by bed section, geographic area, or DRG; (2) the VA adjusted cost per case; (3) the non-VA charge, reimbursement, and/or cost per case; and (4) the dollar and percent differences between the VA adjusted cost and the non-VA cost estimates. Negative percents and dollar amounts in parentheses indicate that the VA adjusted cost is less than the comparative value.

The third table (or Tables a and b) presents selected results for a more complete analysis of DRG-level data. DRG data were analyzed for all DRGs, for those DRGs with 50 or more VA discharges in the relevant geographic area, for DRGs with 100 or more discharges, and for the DRG in each major diagnostic category (MDC) that accounts for the greatest number of discharges in that category. The selection of these 21 DRGs, which are displayed in the second table, was made on the basis of systemwide data so that in some area reports the number of discharges may actually be quite small. A listing of the 21 DRGs and their descriptive titles can be found in Appendix D. Excluded are MDCs 13, 14, and 15 covering problems of the female reproductive system, deliveries, and infant care. For these data, descriptive statistics such as means, minimum and maximum values, and ranges were computed. A correlation analysis measuring the strength of the relationship between the VA adjusted cost per case and the non-VA costs, charges or reimbursements was performed, along with statistical tests for the difference of means between VA and non-VA cost variables. Although some statisticians may question the appropriateness of employing these types of procedures with non-sample data, the results are presented because they tend to highlight certain trends in the data.

HCFA Prospective Payment (PPS) Facilities. Tables 1 through 3(b) present comparisons between VA costs and Medicare charges and reimbursements for all facilities and states under the Medicare prospective payment system. In calculating the VA cost for this analysis, outlier days of care and costs were included, but resident stipends and capital costs were omitted because they are passed through by Medicare.

Table 1 indicates that VA average cost is less than hospital charges for medicine and surgery patients and overall at the national level. Differences range from -25.3 ($701) percent in medicine to -12.1 ($396) percent for all patients. The VA cost for psychiatry, however, is 30.7 ($1,329) percent, higher than hospital charges. VA average costs are higher than Medicare average payments in all categories, ranging from 5.4 percent for medicine patients to 42.6 percent in psychiatry. The overall difference is $493 or 15.1 percent. Two points should be kept in mind with respect to these findings. (1) The cost of care is driven by length of stay. Lengths of stay for VA psychiatry patients are generally longer than for medicine and surgery patients. These longer lengths of stay, therefore, result in higher average costs for psychiatry than for medicine and surgery. Since 1984, added incentives have been introduced to encourage reductions in lengths of stay in psychiatry bed sections. (2) The Medicare reimbursements do not include the $356 deductible or copayments for which the insured is responsible. Although in most cases these charges would be applicable to each discharge, in a small percentage of cases, such as a readmission within 60 days of discharge, the previous deductible would apply. Given the available data, it was impossible to calculate a meaningful average cost per discharge for these additional payments. However, it is clear that the uncovered charges would substantially reduce the difference between VA cost and Medicare reimbursement.

Table 2 displays the results of the comparison between average VA costs and the average amounts charged to and reimbursed by Medicare for 21 high-discharge DRGs. These DRGs account for 295,545 discharges or approximately 30 percent of the workload. VA cost is less than charges for 17 of the 21 DRGs, while the cost is higher than reimbursements for 15. Exactly why the four DRGs with VA costs are higher than charges to Medicare and the six with VA costs less than Medicare payments are inconsistent with the general pattern is unclear. Similar anomalies occur in all analyses at the DRG level. The phenomenon may, in part, be attributable to the use of different cost weighting systems. Because of their greater explanatory power, the VA adopted the New Jersey DRG pricing system to develop its cost weight rather than adopting the HCFA weights.

Tables 3a and 3b show the means and ranges for all DRGs and selected DRGs as indicated. The mean VA cost per DRG is less in each category than the mean charge to Medicare, while the mean reimbursement is less than VA costs. The range, which is the absolute difference between minimum and maximum values, gives an indication of the amount of variability in the data. Overall the range for VA DRG costs is less than Medicare PPS charges or reimbursements, which indicates less deviation from the mean in the VA system. This finding may be a result of the methodology employed in "pricing" the VA DRGs. In the absence of a patient bill, it was impossible to ascertain patient-specific costs of non room and board items. The assumption was that the average cost of medications, procedures, bandages, etc., adequately reflected the cost of treating each patient in a particular category. Therefore, the variability from patient to patient that would have been reflected in charges to individual patients was to some extent averaged at the outset in the VA data.

Correlation analysis shows the strength of the relationship between two variables. The correlation coefficient r has a possible range of values from -1 to +1 with values close to 0 indicating no relationship. The squared correlation coefficient shows the percentage of variation in one variable that can be explained by another variable. In this case, it can be stated that VA costs and non-VA charges show a strong positive relationship and that both the amount and direction of VA costs can be predicted with considerable accuracy from the Medicare data. The statistical test for difference of means is a paired t-test which tests the hypothesis that the difference between two means equals 0. For values of t close to zero, the conclusion is that the means are not different. The probability can be expressed as a percentage and shows the likelihood of finding a value greater than the absolute of t.

The absolute mean difference between VA DRG cost and hospital charges is more than twice as great as the difference between mean VA cost and Medicare reimbursements, indicating that VA costs are closer to what Medicare is willing to pay than to hospital charges. However, the test for the difference in means shows that both differences, are statistically significant at probability less than 0.001, except for the sampling of 21 DRGs.

*Table 1. Comparison between VA costs and Medicare charges and reimbursements for prospective payment system (PPS) facilities at the national level by bed section

	Total VA Discharges	VA Average Adjusted Cost ($)	Average Charge To Medicare			Average Reimbursement By Medicare		
			Charge to Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reimbursement ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	508,462	2,775	3,476	(701)	-25.26	2,626	149	5.37
**Psychiatry	169,492	4,324	2,995	1,329	30.74	2,481	1,843	42.62
Surgery	324,807	3,468	4,290	(822)	-23.70	3,142	326	9.40
National	1,002,761	3,262	3,658	(396)	-12.14	2,769	493	15.11

*Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 70.9 percent of charges billed by PPS facilities.

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E1.

**Table 2. Comparison between VA costs and Medicare charges and reimbursements for all prospective payment system (PPS) facilities for the DRGs producing the greatest number of discharges in each Major Diagnostic Category (MDC).

			Average Charge To Medicare			Average Reimbursement By Medicare		
DRG	Total VA Discharges	VA Average Adjusted Cost ($)	Charge to Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reim-bursement ($)	VA Dollar Difference ($)	VA Percent Difference (%)
014	10,853	4,512	4,497	15	0.33	3,393	1,119	24.80
039	12,411	1,811	2,316	(505)	-27.89	1,151	660	36.44
064	5,089	3,334	3,491	(157)	-4.71	2,954	380	11.40
088	27,665	3,018	3,954	(936)	-30.01	2,584	434	14.38
127	15,494	3,011	3,693	(682)	-22.65	2,615	396	13.15
183	13,940	1,435	1,744	(309)	-21.53	1,173	262	18.26
202	6,395	3,244	4,272	(1,028)	-31.69	3,153	91	2.81
243	12,215	2,396	2,451	(55)	-2.30	1,778	618	25.79
270	8,515	1,082	2,384	(1,302)	-120.33	2,016	(934)	-86.32
294	14,017	2,570	2,791	(221)	-8.60	1,957	613	23.85
311	5,445	1,763	2,157	(394)	-22.35	1,384	379	21.50
336	5,746	4,388	3,884	504	11.49	2,593	1,795	40.91
395	5,660	2,132	2,536	(404)	-18.95	1,914	218	10.23
410	7,363	711	1,864	(1,153)	-162.17	1,037	(326)	-45.85
416	1,934	4,134	5,997	(1,863)	-45.07	4,149	(15)	-0.36
430	66,062	5,171	3,208	1,963	37.96	2,797	2,374	45.91
438	37,621	2,882	2,705	177	6.14	2,067	815	28.28
449	2,056	1,827	2,557	(730)	-39.96	1,771	56	3.07
460	563	2,342	3,886	(1,554)	-65.93	3,494	(1,152)	-49.19
467	12,270	1,210	1,674	(464)	-38.35	2,471	(1,261)	-104.21
468	24,231	3,939	8,345	(4,406)	-111.86	5,956	(2,017)	-51.21
TOTAL	295,545							

**Note: Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 70.9 percent of charges billed by PPS facilities.

Table 3a. Selected statistics for comparison between VA cost and charges to Medicare by all prospective payment system facilities.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	421	3,602	19,386	4,461	29,837	.92	.84	(859)	-9.85	.0001
50 or more	383	3,695	17,038	4,518	29,624	.91	.83	(823)	-9.00	.0001
100 or more	373	3,698	17,038	4,515	29,624	.92	.84	(818)	-8.81	.0001
Top 21 DRGs	21	2,710	4,460	3,353	6,671	.67	.45	(643)	-2.50	.0210

**Table 3b. Selected statistics for comparison between VA cost and Medicare reimbursements to all prospective payment system facilities.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Reimburs. ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	421	3,602	19,386	3,278	22,867	.91	.83	324	5.58	.0001
50 or more	383	3,695	17,038	3,372	22,803	.90	.81	323	5.19	.0001
100 or more	373	3,698	17,038	3,380	22,803	.90	.81	317	5.05	.0001
Top 21 DRGs	21	2,710	4,450	2,496	4,919	.65	.42	215	.99	.3341

**Note: Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 70.9 percent of charges billed by PPS facilities.

HCFA Waivered (non-PPS) Facilities. Tables 4 through 6b present the findings for all facilities exempt from Medicare's prospective payment system. The results again indicate that nationally the VA costs are less than hospital charges to Medicare but higher than Medicare will reimburse. At the bed section level, only VA psychiatry costs are higher than both charges and reimbursements. Once again, it should be borne in mind that Medicare reimburses only 65 percent of charges and these reimbursements do not include deductibles and copayments.

Among the waivered facilities, VA DRG costs, including outliers and unfunded cost adjustments, are less than hospital charges for 19 of the 21 high discharge DRGs but higher than reimbursements for 15. The findings presented in Tables 6a and 6b show similar trends to the findings for PPS facilities. With one exception, VA cost is more highly correlated with Medicare reimbursements than hospital charges. Coupled with smaller dollar differences and smaller scores on the test for difference of means, these results suggest that VA costs are closer to reimbursements than hospital charges.

*Table 4. Comparison between VA costs and Medicare charges and reimbursements for all waivered (non-PPS) facilities at the national level by bed section.

	Total Discharges	VA Cost (Adjusted) ($)	Average Charge To Medicare			Average Reimbursement by Medicare		
			Charge to Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reim-bursement ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	508,475	3,313	4,458	(1,145)	-34.56	2,845	468	14.13
**Psychiatry	169,492	4,922	4,199	723	14.69	3,171	1,751	35.57
Surgery	324,810	4,034	5,225	(1,191)	-29.52	3,062	972	24.10
National	1,002,777	3,819	4,663	(844)	-22.10	2,970	849	22.23

*Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. Medicare reimbursed 65 percent of charges billed by waivered facilities.

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E2.

**Table 5. Comparison between VA costs and Medicare charges and reimbursements for all waivered (non-PPS) facilities for the DRGs producing the greatest number of discharges in each MDC.

			Average Charge To Medicare			Average Reimbursement By Medicare		
DRG	Total Discharges	VA Cost (Adjusted) ($)	Charge to Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reim-bursement ($)	VA Dollar Difference ($)	VA Percent Difference (%)
014	10,853	5,500	5,877	(377)	-6.85	4,021	1,479	26.89
039	12,411	2,101	2,363	(262)	-12.47	853	1,248	59.40
064	5,089	4,054	4,878	(824)	-20.33	3,204	850	20.97
088	27,665	3,524	4,958	(1,434)	-40.69	2,862	662	18.79
127	15,494	3,555	4,530	(975)	-27.43	2,920	635	17.86
183	13,940	1,668	2,385	(717)	-42.99	1,549	119	7.13
202	6,395	3,863	5,124	(1,261)	-32.64	3,476	387	10.02
243	12,215	2,797	3,103	(306)	-10.94	2,450	347	12.41
270	8,515	1,261	3,965	(2,704)	-214.43	2,520	(1,259).	-99.84
294	14,017	3,022	3,575	(553)	-18.30	2,591	431	14.26
311	5,445	2,054	2,596	(542)	-26.39	1,444	610	29.70
336	5,746	5,088	4,291	797	15.66	2,768	2,320	45.60
395	5,660	2,524	3,395	(871)	-34.51	2,260	264	10.46
416	1,934	4,935	6,985	(2,050)	-41.54	4,060	875	17.73
430	66,062	5,887	4,877	1,010	17.16	3,626	2,261	38.41
438	37,621	3,305	3,446	(141)	-4.27	2,751	554	16.76
449	2,056	2,156	3,362	(1,206)	-55.94	2,257	(101)	-4.68
460	563	2,748	6,678	(3,930)	-143.01	4,039	(1,291)	-46.98
467	12,270	1,474	3,188	(1,714)	-116.28	1,860	(386)	-26.19
468	24,231	4,749	9,992	(5,243)	-110.40	5,729	(980)	-20.64
TOTAL	295,545							

**Note: Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. Medicare reimbursed 65 percent of charges billed by waivered facilities.

Table 6a. Selected statistics for comparison between VA cost and charges to Medicare by all waivered facilities.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	422	4,239	21,798	5,515	30,096	.90	.81	(1,276)	-14.24	.0001
50 or more	383	4,351	19,521	5,581	30,096	.90	.81	(1,229)	-13.42	.0001
100 or more	373	4,353	19,521	5,588	30,096	.90	.82	(1,235)	-13.27	.0001
Top 21 DRGs	21	3,196	5,037	4,364	7,920	.66	.43	(1,168)	-3.75	.0013

**Table 6b. Selected statistics for comparison between VA cost and reimbursements by Medicare to all waivered facilities

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	422	4,239	21,798	3,293	14,843	.89	.80	946	11.38	.0001
50 or more	383	4,351	19,521	3,353	14,680	.91	.83	998	12.53	.0001
100 or more	373	4,353	19,521	3,356	14,680	.92	.84	997	12.53	.0001
Top 21 DRGs	21	3,196	5,037	2,789	4,876	.74	.55	406	1.91	0699

**Note: Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 65 percent of charges billed by waivered facilities.

Utah Medicaid. Tables 7 through 9b display the findings for the comparison between Utah Medicaid charges and reimbursements and VA costs in Salt Lake City, the only VA Medical Center in Utah. The VA adjusted cost in this analysis includes outliers, stipends, and the 11.4 percent unfunded cost adjustment. It should also be noted that the VA cost was calculated on the basis of fully supplemented weights since Salt Lake City is a full teaching hospital. Allocations to VA medical centers are supplemented for graduate medical education activities on the basis of the number of residents. The Utah State Department of Health does not maintain separate schedules of reimbursements for teaching and nonteaching hospitals. Their charges and reimbursements, therefore, represent state-wide averages that include all types and sizes of facilities.

Table 7 shows Utah Medicaid average charges and reimbursements per case and the Salt Lake City VA Medical Center average cost per case by bed section and state-wide. With the exception of medicine, the VA cost per case is higher than either charges or reimbursements. The overall difference between VA cost and Medicaid charges is 5.4 percent compared to 29.9 percent difference between cost and reimbursement.

Tables 8 through 9b contain the results of the DRG analyses. The VA cost is less than Medicaid charges for nine of the 21 high discharge DRGs and less than reimbursements for six. The generally smaller range values for VA costs indicate less variation from the mean DRG cost. On the whole, the correlations are lower among these facilities than those at the national level; however, all correlation coefficients are above 0.5. The test for difference of means shows no significant difference between mean VA costs and Medicaid charges, but the differences between costs and reimbursements are statistically significant.

*Table 7. Comparison between Salt Lake City VA costs and Utah Medicaid charges and reimbursements at the state-wide level and by bed section.

			Average Charge To Medicaid			Average Reimbursement By Medicaid		
	Total Discharges	VA Average Adjusted Cost ($)	Charge to Medicaid ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reim-bursement ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	3,657	3,688	3,805	(117)	-3.17	2,848	840	22.78
**Psychiatry	1,556	4,261	3,315	946	22.20	2,336	1,925	45.18
Surgery	2,725	4,327	4,075	252	5.82	3,051	1,276	29.49
Utah	7,938	4,020	3,802	218	5.42	2,817	1,203	29.93

*Utah Medicaid reimbursed approximately 73 percent of billed charges in 1984.

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E3.

**Table 8. Comparison between Salt Lake City VA costs and Utah Medicaid charges and reimbursements for the DRGs producing the greatest number of discharges in each MDC.

			Average Charge To Medicaid			Average Reimbursement By Medicaid		
DRG	Total Discharges	VA Cost (Adjusted) ($)	Average Charge ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Average Reimbursement ($)	Dollar Difference ($)	Percent Difference (%)
014	91	5,549	4,804	745	13.43	3,594	1,955	35.23
039	194	2,067	1,797	270	13.06	1,153	914	44.22
064	41	3,607	3,647	(40)	-1.11	2,806	801	22.21
088	189	3,271	2,612	659	20.15	2,217	1,054	32.22
127	130	3,584	3,194	390	10.88	2,390	1,194	33.31
183	33	1,822	1,137	685	37.60	1,061	761	41.77
202	107	3,712	6,353	(2,641)	-71.15	4,580	(868)	-23.38
243	94	2,653	1,630	1,023	38.56	1,358	1,295	48.81
270	68	1,568	2,642	(1,074)	-68.49	2,040	(472)	-30.10
294	76	3,078	1,773	1,305	42.40	1,618	1,460	47.43
311	28	2,144	2,269	(125)	-5.83	1,706	438	20.43
336	66	4,549	2,507	2,042	44.89	2,200	2,349	51.64
395	15	3,209	2,556	653	20.35	1,944	1,265	39.42
410	5	847	1,930	(1,083)	-127.86	1,308	(461)	-54.43
416	6	3,665	8,772	(5,107)	-139.35	6,080	(2,415)	-65.89
430	460	5,332	4,020	1,312	24.61	2,802	2,530	47.45
438	29	3,715	1,491	2,224	59.87	1,344	2,371	63.82
449	20	1,464	3,289	(1,825)	-124.66	2,194	(730)	-49.86
460	1	3,985	2,558	1,427	35.81	1,967	2,018	50.64
467	2	763	1,037	(274)	-35.91	1,152	(389)	-50.98
468	238	5,310	5,647	(337)	-6.35	4,059	1,251	23.56

TOTAL 1,893

**Note: Utah Medicaid reimbursed approximately 73 percent of billed charges in 1984.

Table 9a. Selected statistics for comparison between Salt Lake City VA costs and hospital charges to Utah Medicaid.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	321	4,054	15,465	4,077	42,164	.55	.31	(24)	-.11	.9119
50 or more	34	3,918	10,865	3,593	12,444	.90	.81	325	1.61	.1174
100 or more	11	3,537	3,265	3,409	4,556	.67	.45	128	.39	.7025
Top 21 DRGs	21	3,138	4,786	3,127	7,735	.52	.27	11	.03	.9766

**Table 9b. Selected statistics for comparison between Salt Lake City VA costs and Utah Medicaid reimbursement.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Reimburs. ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	321	4,054	15,465	3,036	27,356	.62	.39	1,018	7.27	.0001
50 or more	34	3,918	10,865	2,660	8,515	.90	.82	1,257	6.77	.0001
100 or more	11	3,537	3,265	2,535	3,427	.59	.35	1,002	3.45	.0062
Top 21 DRGs	21	3,138	4,786	2,361	5,019	.56	.31	777	2.81	0109

**Note: Utah Medicaid reimbursed approximately 73 percent of billed charges in 1984.

State of Maryland. Tables 10 through 12b show the outcomes of the comparison between Maryland non-VA facilities and all three Maryland VA Medical Centers. Maryland's data included both charges and actual cost estimates. Maryland charge data are state-wide averages per DRG summarizing approximately 625,000 patient bills for calendar year 1984. Maryland cost estimates are based on calculations made by analysts in the Information Services Center to convert charges to patients to the actual cost to facilities of providing a particular service. Maryland was also able to furnish separate schedules of charges and costs for three levels of teaching affiliation. This breakdown permitted application of teaching and nonteaching rates to VA discharges by hospital type. For this reason, the comparison is probably more realistic than comparisons with undifferentiated data. To conform with the Maryland data, high outliers were taken out of the VA cost computation.

As demonstrated in Table 10, the VA average cost per case at the state-wide level is considerably less, 32.2 percent, than hospital charges. Moreover, the VA cost per case is slightly less--$15, or approximately 0.4 percent--than the Maryland estimated cost. At the bed section level, medicine and psychiatry costs are higher than Maryland cost estimates, while surgery costs are less.

The analysis of 21 high discharge DRGs shows VA costs to be lower than charges for 12 DRGs and less than costs for 10. In a number of instances, the differences are over 100 percent. The smaller range values in the VA data shown in Tables 12a and 12b are consistent with this observation and indicate less variation from the mean than Maryland charges and costs. All correlations are above 0.5; however, the tests for difference of means are not significant with the exception of the differences between VA costs and Maryland hospital charges and costs for all DRGs. The absolute dollar differences between VA and Maryland DRG costs are generally smaller than the differences between VA costs and Maryland charges. Coupled with the findings in Table 10, it is clear that costs in Maryland VA medical centers are very close to estimated costs in Maryland non-VA facilities.

Table 10. Comparison between VA costs and Maryland charges and costs for all facilities at the state-wide level and by bed section.

	Total Discharges	VA Cost (Adjusted) ($)	Average Charge In Maryland			Maryland Average Costs		
			Maryland Charges ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Maryland Costs ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	4,552	3,847	3,964	(117)	-3.04	3,491	356	9.25
**Psychiatry	1,834	3,271	3,441	(170)	-5.20	2,987	284	8.68
Surgery	1,973	3,875	5,534	(1,659)	-42.81	4,823	(948)	-24.46
Maryland	8,359	3,680	4,865	(1,185)	-32.20	3,695	(15)	-0.41

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E4.

Table 11. Comparison between VA costs and Maryland charges and costs for the DRGs producing the greatest number of discharges in each MDC.

			Average Charge In Maryland			Maryland Average Costs		
DRG	Total Discharges	VA Cost (Adjusted) ($)	Maryland Charges ($)	VA Dollar Difference ($)	VA Percent Difference (%)	Maryland Costs ($)	VA Dollar Difference ($)	VA Percent Difference (%)
014	95	6,294	6,592	(298)	-4.73	5,767	527	8.37
039	76	1,926	2,714	(788)	-40.91	2,385	(459)	-23.83
064	30	5,842	5,311	531	9.09	4,617	1,225	20.97
088	253	4,377	4,127	250	5.71	3,716	661	15.10
127	186	4,097	4,551	(454)	-11.08	4,007	90	2.20
183	79	2,112	1,821	291	13.78	1,643	469	22.21
202	109	5,807	4,593	1,214	20.91	4,101	1,706	29.38
243	113	3,385	2,564	821	24.25	2,273	1,112	32.85
270	67	1,218	3,329	(2,111)	-173.32	2,886	(1,668)	-136.95
294	104	3,550	3,232	318	8.96	2,871	679	19.13
311	47	2,084	2,879	(795)	-38.15	2,521	(437)	-20.97
336	40	5,284	4,570	714	13.51	3,968	1,316	24.91
395	51	3,238	4,155	(917)	-28.32	3,650	(412)	-12.72
410	38	1,391	2,604	(1,213)	-87.20	2,257	(866)	-62.26
416	22	4,405	10,044	(5,639)	-128.01	8,719	(4,314)	-97.93
430	592	4,185	4,172	13	.31	3,743	442	10.56
438	254	2,501	2,918	(417)	-16.67	2,573	(72)	-2.88
449	11	2,512	3,767	(1,255)	-49.96	3,314	(802)	-31.93
460	6	2,662	2,537	125	4.70	2,219	443	16.64
467	104	1,618	1,934	(316)	-19.53	1,692	(74)	-4.57
468	194	4,163	9,568	(5,405)	-129.83	8,359	(4,196)	-100.79
TOTAL	2,471							

Table 12a. Selected statistics for comparison between VA cost and Maryland charges per DRG.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	345	4,380	14,244	5,311	26,799	.71	.50	(931)	-6.11	.0001
50 or more	42	3,463	5,346	3,657	8,164	.63	.40	(195)	-1.09	.2812
100 or more	17	3,458	4,189	3,733	7,634	.55	.30	(275)	-.78	.4468
Top 21 DRGs	21	3,460	5,076	4,190	8,223	.60	.36	(730)	-1.88	.0744

Table 12b. Selected statistics for comparison between VA cost and Maryland costs per DRG.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Cost ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	345	4,380	14,244	4,652	23,609	.71	.50	(272)	-2.04	.0426
50 or more	42	3,463	5,346	3,202	7,105	.61	.37	261	1.53	.1336
100 or more	17	3,458	4,189	3,267	6,667	.54	.29	191	.60	.5565
Top 21 DRGs	21	3,460	5,076	3,680	7,076	.60	.36	(220)	-.64	.5265

Northeast Teaching Hospital Data. Tables 13 through 15 display the results of the comparison between costs in a large teaching hospital in the Northeast and VA fully supplemented teaching hospitals in the same geographic region. The VA cost estimates include resident stipends, outlier costs, and the unfunded cost adjustment of 11.4 percent. They are also calculated on the basis of fully supplemented cost weights.

As shown in Table 13, the area-wide VA cost per case is $895 or 24.0 percent less than the estimated costs at the non-VA facility. Costs in all three bed sections, including psychiatry, are from 16.5 to 33.7 percent less. At the DRG level, the VA cost is less for 14 of the high-discharge DRGs. Correlation coefficients are all above 0.65, and, with one exception, tests for the difference of means are significant at probability less than or equal to 0.001.

Table 13. Comparison between costs reported by a major teaching hospital in the Northeast and costs in fully affiliated VA medical centers in the same area by bed section.

	Total Discharges	VA Cost (Adjusted) ($)	Average NE Teaching Hosp. Cost ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	19,182	3,303	4,180	(877)	-26.55
**Psychiatry	5,733	4,436	5,931	(1,495)	-33.70
Surgery	13,392	4,034	4,699	(665)	-16.48
Region	38,307	3,728	4,623	(895)	-24.01

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E5.

Table 14. Comparison between costs reported by a major teaching hospital in the Northeast and VA costs in fully supplemented hospitals in the same area for those DRGs producing the greatest number of discharges in each MDC.

DRG	Total Discharges	VA Cost (Adjusted) ($)	Average NE Teaching Hosp. Cost ($)	VA Dollar Difference ($)	VA Percent Difference (%)
014	387	5,823	9,734	(3,911)	-67.16
039	282	2,028	2,355	(327)	-16.12
064	203	4,455	2,393	2,062	46.29
088	757	4,208	2,694	1,514	35.98
127	463	3,733	5,101	(1,368)	-36.65
183	671	1,278	1,359	(81)	-6.34
202	306	3,219	6,550	(3,331)	-103.48
243	362	2,760	3,049	(289)	-10.47
270	504	1,087	1,917	(830)	-76.36
294	315	2,934	2,702	232	7.91
311	346	1,466	2,028	(562)	-38.34
336	173	4,913	4,003	910	18.52
395	269	1,684	6,000	(4,316)	-256.29
410	601	697	694	3	.43
416	52	5,477	8,782	(3,305)	-60.34
430	2,025	5,921	7,492	(1,571)	-26.53
438	1,597	3,229	4,420	(1,191)	-36.88
449	75	1,640	2,520	(880)	-53.66
460	17	3,365	654	2,711	80.56
467	455	1,550	525	1,025	66.13
468	1,048	4,767	7,191	(2,424)	-50.85
TOTAL	10,908				

Table 15. Selected statistics for comparison between cost per DRG reported by a major teaching hospital in the Northeast and costs per DRG and in fully supplemented VA Medical Centers in the same area.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean Non-VA Cost ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	373	4,365	20,337	5,253	32,517	.69	.48	(887)	-4.47	.0001
50 or more	178	3,785	17,120	4,736	21,708	.72	.51	(951)	-4.38	.0001
100 or more	103	3,539	17,082	4,488	20,611	.72	.52	(949)	-3.45	.0008
Top 21 DRGs	21	3,154	5,224	3,913	9,209	.73	.53	(759)	-1.82	.0844

California Health Facilities Commission. The data obtained from the California Health Facilities Commission include only charges by all California hospitals to patients discharged in 1983. These charges are compared to costs in all 10 California VA Medical Centers. The VA cost calculated for this comparison includes resident stipends, outlier costs, and the 11.4 percent adjustment. The results are presented in Tables 16 through 18.

State-wide, California hospitals are submitting bills that are 22.4 percent greater than VA costs. This finding is consistent with the difference between VA costs and hospital charges in the preceeding analyses. VA costs are greater for two of the 21 high discharge DRGs. All correlation coefficients are above 0.8, indicating a strong relationship between costs and charges. However, the smaller range values indicate less variation from the mean among VA costs per DRG than among California charges. The tests for difference of means show mean VA costs to be significantly less than California charges.

Table 16. Comparison between charges reported to the California Health Facilities Commission and costs in California VA Medical Centers by bed section and state-wide.

	Total Discharges	VA Cost (Adjusted) ($)	Average California Charge ($)	VA Dollar Difference ($)	VA Percent Difference (%)
Medicine	39,037	4,224	5,386	(1,162)	-27.51
**Psychiatry	14,142	5,663	5,726	(63)	-1.11
Surgery	30,042	4,419	5,690	(1,271)	-28.76
California	83,221	4,539	5,554	(1,015)	-22.36

**Because some psychiatry patients are discharged from medical and surgical bed sections, a separate analysis of psychiatric DRGs was conducted. The results are reported in Appendix E, Table E6.

Table 17. Comparison between charges reported to the California Health Facilities Commission and costs in California VA Medical Centers for the DRGs producing the greatest numberof discharges in each MDC.

DRG	Total Discharges	VA Cost (Adjusted) ($)	Average California Charge ($)	VA Dollar Difference ($)	VA Percent Difference (%)
014	1,022	7,146	8,322	(1,176)	-16.46
039	1,326	2,268	2,728	(460)	-20.28
064	389	4,830	5,268	(438)	-9.07
088	2,062	4,122	6,977	(2,855)	-69.26
127	1,377	4,271	6,042	(1,771)	-41.47
183	916	1,821	2,123	(302)	-16.58
202	614	4,450	6,642	(2,192)	-49.26
243	894	3,532	3,092	440	12.46
270	622	1,718	2,437	(719)	-41.85
294	874	4,062	4,478	(416)	-10.24
311	440	2,104	2,338	(234)	-11.12
336	544	5,272	4,932	340	6.45
395	559	2,729	3,745	(1,016)	-37.23
410	338	1,458	2,723	(1,265)	-86.76
416	147	6,141	9,868	(3,727)	-60.69
430	5,836	6,208	6,448	(240)	-3.87
438	2,627	4,358	4,681	(323)	-7.41
449	148	2,461	4,191	(1,730)	-70.30
460	40	3,267	4,486	(1,219)	-37.31
467	11,314	1,400	2,343	(943)	-67.36
468	1,901	5,753	12,065	(6,312)	-109.72
TOTAL	33,990				

Table 18. Selected statistics for comparison between charges per DRG reported to the California Health Facilities Commission by all California hospitals and costs in California VA Medical Centers.

Discharges Per DRG	Number of DRGs	Mean VA Cost ($)	Range ($)	Mean California Charge ($)	Range ($)	Correlation Coeff. (r)	r Square	Dollar Difference ($)	t	Prob
Total Disch	410	5,069	26,686	6,213	41,253	.85	.73	(1,144)	-8.07	.0001
50 or more	267	4,821	18,968	5,931	28,826	.92	.85	(1,109)	-8.60	.0001
100 or more	198	4,582	18,968	5,615	28,240	.94	.88	(1,032)	-8.03	.0001
Top 21 DRGs	21	3,780	5,746	5,044	9,942	.84	.70	(1,265)	-3.77	.0012

LENGTH OF STAY

The fact that lengths of stay are longer in the VA than in the private sector is common knowledge. It is also widely recognized that length of stay is a significant contributor to the cost of an episode of medical care. A separate analysis was carried out to compare average lengths of stay in VA facilities with those in non-VA facilities. This analysis was based on each reporting unit's own lengths of stay and discharges rather than applying non-VA data to VA patients. Only DRGs appearing both in the VA and non-VA 1984 data bases were used in the estimates.

The results of this analysis showed that, although VA average lengths of stay may be as much as twice as long as those in the private sector in some instances, this difference does not result in costs that are twice as high. In part, the differences in length of stay are due to differences in practice. Admissions in the private sector customarily result from referrals by private physicians. In such cases, preadmission diagnostic and laboratory work-ups are performed on an outpatient basis. Admission to a VA medical center may come from an outpatient clinic, but many admissions are direct, with work-ups carried out on an inpatient basis.

A second reason for longer lengths of stay in VA medical centers is the lack of suitable outplacement alternatives for some VA patients. It is frequently necessary to keep patients until they can care for themselves or arrangements can be made for adequate post-operative or post-treatment care. A third factor contributing to longer lengths of stay is the number of long-term inpatient psychiatry patients. While the new resource allocation models and recent policy decisions provide incentives to deinstitutionalize many of these patients, it appears unlikely that long-term residential care can be eliminated. Similar patients in the private sector are often removed from acute-care settings and placed in state institutions or private psychiatric hospitals.

Until 1985 data from the patient treatment file become available, the effects of the DRG-based resource allocation models and recent policy decisions on lengths of stay cannot be accurately evaluated. However, partial reports indicate that they are coming down. Between FY 84 and 85 average length of stay dropped approximately 6 percent.

CONCLUSION

The purpose of this analysis was to develop a VA acute-care cost per case that could be compared to the cost per case in non-VA health care facilities. The use of diagnosis related groups for resource allocation in the VA and for pricing purposes in the non-VA sector provided the basis for developing cost estimates and furnished the technique for comparing similar case mixes. Comparisons were made at the national level or at the same geographic level as the comparable data base. Where possible, comparisons were based on similar facilities.

Although the data presented in the foregoing analyses do not show the VA acute care system to be definitively more or less costly than care in non-VA facilities, certain conclusions can be drawn.

1. With the exception of the Medicaid comparison, the VA cost per case at the highest level of aggregation is from approximately 12 to 30 percent less than hospitals are charging for their services to a similar case mix. The Medicaid analysis compares only one VA full teaching facility against an entire state, including all types of facilities—rural, urban, teaching, and non-teaching.

2. Although the VA cost per case is higher than third-party reimbursements, these payments do not reflect deductibles and copayments which would substantially reduce the difference. While not costs to the federal government, these payments are part of the cost of health care and, as such, represent costs to individuals or to society.

3. Actual cost per case estimates available from the Northeast teaching hospital and Maryland suggest that VA costs were less or approximately the same.

4. In those comparisons for which differentiated schedules of charges and reimbursements were unavailable, it is reasonable to assume that the high proportion of VA discharges from teaching hospitals understates the non-VA cost per case. Where comparisons could be made according to facility type, as in Maryland and the Northeast teaching hospital, the VA cost was less or approximately the same.

5. At the bed section level (medicine, surgery, and psychiatry services), the cost of psychiatric services in the VA tends to be higher than the comparable cost estimate in non-VA facilities. For Medicare and Medicaid, the VA cost exceeds even hospital charges. A notable exception to this trend occurs in the Northeast teaching hospital comparison, where the VA cost per case is 33.5 percent less than their estimate for treating similar cases. It is assumed that incentives in the VA DRG allocation methodology will encourage greater use of outpatient psychiatric services and reduce these disparities in future years.

6. At the DRG level, the tables reflect considerable variation from group to group between VA and non-VA costs. Experience has shown that the data tend to be somewhat unstable at lower levels of aggregation. However, the generally high correlations tend to support the conclusion that the VA resource allocation method is consistent with non-VA pricing policies.

7. It is expected that incentives in the resource allocation methodologies will produce reductions in length of stay, leading to greater productivity and efficiency in VA medical centers.

In summation, VA costs are generally significantly less than most hospitals are currently charging their clients. Furthermore, the data and analyses support the conclusion that VA costs are comparable to, and consistent with, estimated costs in the private sector.

APPENDIX A

VA COST ELEMENTS INCLUDED IN EACH COMPARISON

	VA OUTLIERS*	VA CAPITAL COSTS	VA EDUCATION COSTS
HCFA PPS	Yes	No	No
HCFA non-PPS	Yes	Yes	Yes
Utah Medicaid	Yes	Yes	Yes
NE teaching hosp.	Yes	Yes	Yes
Maryland	No	Yes	Yes
California	Yes	Yes	Yes

*Except in the special analysis of psychiatric DRGs 424-438 in Appendix E.

APPENDIX B

CALCULATION OF THE VA AVERAGE COST PER DRG DISCHARGE

The average VA cost per DRG discharge is defined as follows:

$$\text{Average Cost} = (\text{DE\$} + \text{IND\$} + \text{STIP\$}) - \text{PHYS\$} + \text{CAPITAL\$}$$

Where DE$ are average direct and education costs, IND$ are average indirect costs, STIP$ are average resident stipend costs, and PHYS$ are average physician costs.

For VA resource allocation purposes, the diagnosis related group (DRG) patient classification system was adopted. A relative value or number of weights was assigned to each DRG discharge using the New Jersey DRG pricing system. In the VA, these weights are referred to as weighted work units (WWUs).[5] These weighted work units were employed in calculating the average VA cost per discharge at each level of aggregation. The initial step required computation of a direct and education cost per weighted work unit for each bed service in each facility. This step involved the following calculations:

1. The total number of discharges by DRG in each bed service in each facility was multiplied by the number of weighted work units assigned to that DRG.

$$\text{Total WWUs per DRG} = \text{discharges per DRG} \times \text{WWU per DRG}$$

2. The total weighted work units per DRG and the discharges were summed to the bed service level for each facility.

$$\text{Total WWUs per bed service} = \text{sum of Total WWUs per DRG}$$
$$\text{Total Discharges per bed service} = \text{sum of discharges per DRG}$$

3. The total direct and education expenditures for each bed service in each facility as reported in the RCS 10-0141 were divided by the total weighted work units. The result of this calculation was an average direct and education cost per weighted work unit specific to each bed section in each facility.

$$\text{Bed Service Average cost per WWU} = \frac{\text{Total Dir. \& Educ. Expenditures}}{\text{Total Weighted Work Units}}$$

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[5] The validity of the weights was established by means of regression analysis. Regression analysis measures the strength of the relationship between a dependent variable and one or more independent variables and produces a squared regression coefficient R-square. R-square can be interpreted as the percentage of variation in the dependent variable explained by the independent variable. It can also be used to indicate how accurately the value of the dependent variable could be predicted from the value of the independent variable. For purposes of validating the cost weights, the total weighted work units produced in 1983 and 1984 were regressed on 1984 reported direct and education expenditures. The result using 1983 weighted work units to predict 1984 direct and education expenditures was R-square = .75. The result using 1984 weighted work units was R-square = .85. The conclusion is that these weights are accurate predictors of direct and education expenditures.

The cost per weighted work unit specific to each facility and bed section was used to calculate average direct and education costs per DRG in the following manner:

1. The total number of weighted work units per DRG from each bed service in each facility was multiplied by the average cost per weighted work unit for that facility and bed service, to yield the total direct and education dollars per DRG for each bed service in each facility.

D & E DRG cost (by facility and bed service) = Total WWUs per DRG (by facility and bed service) x WWU Unit Cost

2. The direct and education cost and the number of weighted work units per DRG by facility and bed service were summed for each DRG to the system-wide level.

Total D & E Cost per DRG = sum of D & E DRG cost (by facility & bed service)

Total WWUs per DRG = sum of WWUs per DRG (by facility and bed service)

3. The system-wide total direct and education cost per DRG was divided by the total number of weighted work units per DRG to obtain a weighted work unit cost per DRG.

$$\text{WWU Cost per DRG (system-wide)} = \frac{\text{Total D \& E Cost per DRG}}{\text{Total WWUs per DRG}}$$

4. Finally the average number of weighted work units per DRG discharge, calculated by dividing the total number of weighted work units per discharge by the total number of discharges per DRG, was multiplied by the DRG weighted work unit cost to obtain the average direct and education cost per DRG discharge.

$$\text{Average WWUs per Discharge} = \frac{\text{Total WWUs per DRG}}{\text{Total Discharges per DRG}}$$

Average D & E $ per DRG Discharge = Average WWUs per Discharge x WWU Unit Cost per DRG (system-wide)

A similar process of disaggregation and reaggregation was employed in calculating the indirect, stipend and physician portions of the total cost per DRG. However, the indirect and stipend unit costs were based on bed days of care rather than on weighted work units because these costs, which include building maintenance, laundry, supplies, and resident stipends were not considered to vary according to patient condition as much as direct and physician costs.

The average cost per VA discharge at the bed section and system-wide levels were computed by the same method, with unit costs recalculated at each level of aggregation.

APPENDIX C.

EXPLANATION OF UNFUNDED COSTS*

The VA's unfunded costs were accounted for by increasing the VA basic cost per case at each level of aggregation by 11.4 percent. The 11.4 percent adjustment includes the following factors:

Depreciation of Equipment	0.7%
Depreciation of Buildings	1.5%
Central Office Med. Admin. Expenses	0.7%
Interest on Net Capital Investments	8.5%
Total	11.4%

Depreciation of equipment is based upon the estimated useful life of depreciable items, up to 10 years. Depreciation of buildings is straight line, based on 40 years of useful life. The depreciation of buildings may actually be overstated since many of the VA's older buildings are already fully depreciated. Central Office medical administration expenses were computed in the Central Office. Interest on net capital investments reflects 1984 interest rates.

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*Prepared by the Office of Resource Management, Department of Medicine and Surgery.

APPENDIX D

LISTING OF 21 DRGS PRODUCING THE GREATEST NUMBER OF DISCHARGES IN EACH MAJOR DIAGNOSTIC CATEGORY (MDC)

MDC*	DRG	DESCRIPTIVE TITLE
1	14	Specific cerebrovascular disorder other than transient ischemic attack without surgery.
2	39	Disease or disorder of eye with lenticular surgery.
3	64	Malignancy of ear, nose, or throat without surgery
4	88	Chronic obstructive pulmonary disease without surgery.
5	127	Heart failure, shock without surgery or cardiac catheterization.
6	183	Esophagitis, miscellaneous disorder without surgery, age between 17 and 70 and no comorbidity or complication.
7	202	Cirrhosis, alcholic hepatitis without surgery.
8	243	Disease or disorder of back without surgery.
9	270	Disease or disorder of the skin, subcutaneous tissue or breast with other OR procedures, age less than 70 and no comorbidity or complication.
10	294	Diabetes without surgery, age greater than 35.
11	311	Disease or disorder of kidney or urinary tract with transurethral surgery, age less than 70 and no comorbidity or complication.
12	336	Disease or disorder of male reproductive system with transurethral prostatectomy, age greater than 69 and/or comorbidity or complication.
16	395	Red blood cell disorder without surgery, age greater than 17.
17	410	Chemotherapy without surgery.
18	416	Septicemia without surgery, age greater than 17.
19	430	Psychosis without surgery.

MDC*	DRG	DESCRIPTIVE TITLE
20	438	Substance-induced organic mental syndrome.
21	449	Toxic effect of drug without surgery, age greater than 69 and/or comorbidity or complication.
22	460	Other burn without surgery, not transferred.
23	467	Other factors influencing health status without surgery.
24	468	Unrelated OR procedure (ungroupable).

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*MDCs 13, 14, and 15 were omitted. These MDCs cover female reproductive disorders, pregnancy and childbirth, and treatment of neonates and newborns.

APPENDIX E

ANALYSIS OF PSYCHIATRIC DISCHARGES

Because psychiatric care in the VA differs from psychiatric care in non-VA facilities in several important respects, a separate analysis was carried out on psychiatric discharges. The VA psychiatric patient population includes both acute cases as well as a significant number of chronic, long-term cases of a type ordinarily found only in state or county hospitals or in private long-term residential facilities. Moreover, VA psychiatric inpatients are provided a full range of medical services (e.g., dental care or necessary surgery) concurrently with their psychiatric treatment.

Since the non-VA comparative data reflect primarily acute-care experience, VA outlier bed days of care and weighted work units were subtracted from VA total bed days of care and weighted work units in order to better capture the average cost of the acute portion of a psychiatric discharge in the VA. The results of the analysis of psychiatric DRGs are reported in Tables E1-E8 of this Appendix. Because some psychiatric patients are discharged from medicine and surgery bed sections, the average cost per case was calculated by bed section as well as at the system-wide level. In addition, the average cost per VA discharge was calculated separately for DRGs 430 and 438, the DRGs producing the greatest number of discharges in Major Diagnostic Categories 19 and 20.

The tables analyzing Medicare, Medicaid, and Maryland data are subdivided to display charges and reimbursements or costs separately. Column 1 indicates the level of analysis. Column 2 shows the number of VA discharges for each level. Column 3 is the VA average length of stay with high outlier bed days of care taken out. Column 4 shows the non-VA average length of stay. Column 5 is the VA average cost per discharge. Column 6 indicates the average non-VA charge and reimbursement or cost. Columns 7 and 8 show the dollar and percent differences between the VA average cost per discharge and the non-VA average charge, reimbursement or cost. Dollars in parentheses and negative percents indicate that the VA average cost is less than the non-VA charge, reimbursement, or cost.

Table E7 shows the number of VA discharges, average lengths of stay, average VA costs, and average non-VA charges and reimbursements or costs for DRGs 430 and 438. Table E8 shows dollar and percent differences between the VA average cost and non-VA charges and reimbursements or costs.

HCFA Prospective Pay (PPS). Table E1 compares VA average lengths of stay and VA average costs per discharge with Medicare prospective pay average length of stay and average charges and reimbursements. Because Medicare reimbursements to PPS facilities do not include the indirect costs of medical education, resident stipends were omitted in calculating the VA average cost per case. This omission accounts for the difference in the VA average cost per case shown in Table E2.

Medicare PPS data are based on discharges from acute general and medical hospitals. These data do not include discharges from non-VA psychiatric hospitals or distinct part psychiatric units in non-VA acute general hospitals. Both psychiatric hospitals and distinct part psychiatric units are exempt from Medicare's prospective payment requirements. It is therefore likely that PPS charges and reimbursements reflect a different type of psychiatric patient and a different type of treatment than are found in most VA medical centers or in non-VA waivered facilities.

The VA average cost per discharge at the national level for the non-outlier portion of a psychiatric episode of care is $51 (1.73%) higher than Medicare charges. The VA average cost is $552 (18.74%) higher than Medicare reimbursements; however, Medicare reimbursements do not include deductibles and copayments for which the insured is responsible. The most costly non-outlier psychiatric discharges are those from surgical bed sections, but these represent only about 1 percent of total psychiatric discharges. In the analysis displayed in Table 1 (p. 12), the average cost per discharge from psychiatry bed sections is highest. This finding probably reflects the longer lengths of stay of chronic psychiatric patients.

The overall non-outlier VA average length of stay is 21.32 days and 9.04 days for Medicare PPS patients. A statistical test for the difference of mean lengths of stay for psychiatric DRGs shows that the differences between Medicare and VA lengths of stay are significant; however, the test for difference of mean VA cost and mean Medicare charges and reimbursements showed no significant differences. Assuming that these charges and reimbursements are a reasonable proxy for costs, it can be concluded that VA costs for acute length-of-stay psychiatric care are comparable to Medicare costs.

HCFA Non-Prospective Pay (Waivered). In addition to facilities in the waivered states of Maryland, New Jersey, New York, and Massachusetts, the Medicare waivered data include psychiatric hospitals (except for state mental institutions) and distinct part psychiatric units in acute general and medical facilities. These Medicare average lengths of stay are not significantly different from lengths of stay in the VA.

At the national level, charges to Medicare are $693 (20.61%) higher than the VA average cost per discharge. Reimbursements by Medicare are $227 (8.24%) less than VA average cost. The results of the statistical test for the difference of means between the VA average cost and Medicare average charges and reimbursements for psychiatric DRGs shows the VA cost to be significantly less than charges, but not significantly different from Medicare reimbursements. These findings indicate that non-outlier discharges from VA facilities are quite similar to Medicare discharges from psychiatric and distinct part psychiatric facilities in the private sector.

Utah Medicaid. The Utah Medicaid data cover all non-VA acute general and medical facilities in Utah, while the VA data represent only one VA fully affiliated medical center. At the state-wide level, the mean VA non-outlier length of stay is 17.95 days, but 14.16 days for Medicaid patients. The difference in mean lengths of stay for psychiatric DRGs is insignificant, as is the mean difference between VA cost and hospital charges to Medicaid. However, the difference between VA cost and Medicaid reimbursements is significant. During the period covered by this analysis, Utah Medicaid reimbused approximately 70 percent of billed charges for psychiatric care. By contrast, Medicare reimbursed approximately 83 percent of psychiatry charges billed by PPS facilities and approximately 76 percent of waivered charges. Therefore, it appears that Medicaid reimbursements may not adequately cover the cost of psychiatric care.

Maryland. The Maryland data include all acute general medical and surgical hospitals in the State. They do not cover state hospitals or private psychiatric hospitals. The average length of stay is 11.39 days in Maryland and 21.71 days in the VA. The difference in mean lengths of stay for psychiatric DRGs is significant. However, the difference between the VA average cost per DRG and the Maryland estimated cost is not significant. This finding is consistent with the previous analysis of all discharges.

Northeast Teaching Hospital. This analysis compares psychiatric discharges from a large teaching hospital in the Northeast with psychiatric discharges from fully affiliated VA hospitals located in the same geographic region. DRG 435 was eliminated from this analysis because the Northeast Teaching Hospital had only one discharge from that DRG which cost over $22,000. This outlier distorted the teaching hospital's average cost for psychiatric discharges. The averge lengths of stay for the teaching hospital and VA facilities are approximately the same. However, the mean VA cost per DRG is significantly less than the cost per DRG in the teaching hospital.

California. The California Health Facilities Commission charge data show a state-wide length of stay for acute care psychiatry of 14.66 days. The VA overall length of stay is 24.86; however, the mean difference for all psychiatric DRGs is not statistically significant. The California state-wide average charge per psychiatric discharge exceeds the VA average cost by $1,791 (47.04 percent). The mean differences between California charges and VA costs for these DRGs are significant.

In summation, the analysis of psychiatric DRGs supports the conclusion that the cost of acute psychiatry in VA facilities is reasonably consistent with costs in non-VA facilities.

*Table E1. Comparison between VA costs and Medicare prospective payment system (PPS) charges and reimbursements for psychiatric DRGs 424-438 at the national level and by bed section.
(See Test Table 1 for all DRGs)

	Total Discharges	VA Average Length of Stay	Medicare Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Charge To Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)
**Medicine	38,466	11.20	8.98	2,073	2,782	(709)	-34.20
Psychiatry	160,610	23.85	9.00	3,143	2,911	232	7.38
**Surgery	2,080	13.11	9.23	3,355	3,815	(460)	-13.71
National	201,156	21.32	9.04	2,946	2,895	51	1.73

	Total Discharges	VA Average Length of Stay	Medicare Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Reimbursement By Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)
**Medicine	38,466	11.20	8.98	2,073	2,230	(157)	-7.57
Psychiatry	160,610	23.85	9.00	3,143	2,422	721	22.94
**Surgery	2,080	13.11	9.23	3,355	3,308	47	1.40
National	201,156	21.32	9.04	2,946	2,394	552	18.74

*Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 70.9 percent of charges billed by PPS facilities.

**Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

*Table E2. Comparison between VA costs and Medicare waivered (non PPS) facilities charges and reimbursements for psychiatric DRGs 424-438 at the national level and by bed section.
(See Test Table for all DRGs)

	Total Discharges	VA Average Length of Stay	Medicare Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Charge To Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)
**Medicine	38,466	11.20	19.69	2,420	3,746	(1,326)	-54.79
Psychiatry	160,610	23.85	19.63	3,575	4,113	(538)	-15.05
**Surgery	2,080	13.11	20.12	3,884	5,243	(1,359)	-34.99
National	201,156	21.32	19.76	3,362	4,055	(693)	-20.61

	Total Discharges	VA Average Length of Stay	Medicare Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Reimbursement By Medicare ($)	VA Dollar Difference ($)	VA Percent Difference (%)
**Medicine	38,466	11.20	19.69	2,420	2,863	(443)	-18.31
Psychiatry	160,610	23.85	19.63	3,575	3,129	446	12.48
**Surgery	2,080	13.11	20.12	3,884	3,795	89	2.29
National	201,156	21.32	19.76	3,362	3,085	277	8.24

*Medicare reimbursement amounts do not include deductibles or copayments paid by the patient or other third-party payors. In 1984, Medicare reimbursed 70.9 percent of charges billed by PPS facilities.

**Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

Table E3. Comparison between VA costs and Salt Lake City, Utah Medicaid charges and reimbursements for psychiatric DRGs 424-438 at the state-wide level and by bed section.
(See Test Table for all DRGs)

	Total Discharges	VA Average Length of Stay	Medicaid Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Charge To Medicaid ($)	VA Dollar Difference ($)	VA Percent Difference (%)
*Medicine	363	7.59	13.71	2,704	2,955	(251)	-9.28
Psychiatry	1,505	20.57	13.71	4,042	3,245	797	19.72
*Surgery	21	9.00	15.70	3,750	4,694	(944)	-25.17
Utah	1,889	17.95	14.16	3,790	3,205	585	15.44

	Total Discharges	VA Average Length of Stay	Medicaid Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Reimbursement By Medicaid ($)	VA Dollar Difference ($)	VA Percent Difference (%)
*Medicine	363	7.59	13.71	2,704	2,123	581	21.49
Psychiatry	1,505	20.57	13.71	4,042	2,286	1,756	43.44
*Surgery	21	9.00	15.70	3,750	3,291	459	12.24
Utah	1,889	17.95	14.16	3,790	2,266	1,524	40.21

*Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

Table E4. Comparison between VA costs and Maryland charges and costs for psychiatric DRGs 424-438 at the state-wide level and by bed section.

(See Test Table for all DRGs)

	Total Discharges	VA Average Length of Stay	Maryland Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Charge In Maryland ($)	VA Dollar Difference ($)	VA Percent Difference (%)
*Medicine	274	17.11	11.76	3,199	3,363	(164)	-5.13
Psychiatry	1,573	22.65	11.37	3,264	3,492	(228)	-6.99
*Surgery	13	4.85	8.74	2,938	6,504	(3,566)	-121.38
Maryland	1,860	21.71	11.39	3,251	5,685	(2,434)	-74.87

	Total Discharges	VA Average Length of Stay	Maryland Ave Length of Stay	VA Average Cost Per Discharge ($)	Average Cost In Maryland ($)	VA Dollar Difference ($)	VA Percent Difference (%)
*Medicine	274	17.11	11.76	3,199	3,004	195	6.10
Psychiatry	1,573	22.65	11.37	3,264	3,088	176	5.39
*Surgery	13	4.85	8.74	2,938	5,647	(2,709)	-92.21
Maryland	1,860	21.71	11.39	3,251	3,094	157	4.83

*Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

Table E5. Comparison between costs reported by a major teaching hospital in the Northeast and costs in fully supplemented VA medical centers in the same area for psychiatric DRGs 424-438 by bed section.
(See Test Table 13)

	Total Discharges	VA Average Length of Stay	NE Teaching Hospital Ave Length of Stay	VA Average Cost Per Discharge	Average NE Teaching Hosp. Cost	VA Dollar Difference	VA Percent Difference
*Medicine	821	13.18	20.33	2,788	4,488	(1,700)	-60.98
Psychiatry	5,133	22.02	20.66	2,958	6,131	(3,173)	-107.27
*Surgery	59	13.93	22.14	4,088	7,146	(3,058)	-74.80
Region	6,013	20.74	20.81	2,947	5,916	(2,969)	-100.75

NOTE: DRG 435 was eliminated from the analysis because the Northeast teaching hospital had only one discharge which cost over $22,000. This outlier distorted the teaching hospital's average costs for this group of DRGs.

*Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

Table E6. Comparison between charges reported to the California Health Facilities Commission and costs in California VA Medical Centers for psychiatric DRGs 424-438 state-wide and by bed section.
(See Test Table 16)

	Total Discharges	VA Average Length of Stay	California Ave Length of Stay	VA Average Cost Per Discharge	Average Charge In California	VA Dollar Difference	VA Percent Difference
*Medicine	1,303	13.00	14.72	3,468	5,343	(1,875)	-54.07
Psychiatry	13,791	25.67	14.77	3,841	5,588	(1,747)	-45.48
*Surgery	149	13.14	14.35	4,917	8,768	(3,851)	-78.32
California	15,243	24.86	14.66	3,807	5,598	(1,791)	-47.04

*Some psychiatry patients are discharged from medical and surgical bed sections. The discharges in this table all have psychiatric DRGs.

Table E7. Comparison between VA costs and non-VA charges, reimbursements, or costs for the psychiatric DRGs producing the greatest number of discharges in Major Diagnostic Categories 19 and 20.

	Total Discharges	VA Average Length of Stay	Non-VA Ave Length Of Stay	VA Average Cost Per Discharge ($)	Average Charge By Non-VA Facilities ($)	Ave Reimbursement To Non-VA Facilities ($)	Non-VA Average Cost
HCFA PPS							
DRG 430	66,062	26.89	11.00	3,586	3,208	2,797	-----
DRG 438	37,621	16.52	7.80	2,414	2,705	2,067	-----
HCFA non-PPS							
DRG 430	66,062	26.89	21.60	4,079	4,877	3,626	-----
DRG 438	37,621	16.52	12.90	2,765	3,446	2,751	-----
Utah Medicaid							
DRG 430	460	21.23	15.66	4,900	4,020	2,802	-----
DRG 438	29	13.83	5.67	3,258	1,491	1,344	-----
Maryland							
DRG 430	592	34.42	16.14	4,185	4,172	-----	3,743
DRG 438	254	13.23	7.04	2,501	2,918	-----	2,573
NE Teaching Hospital							
DRG 430	2,025	28.06	27.00	3,640	-----	-----	7,492
DRG 438	1,597	14.76	9.87	2,570	-----	-----	4,420
California							
DRG 430	5,836	27.81	15.86	4,517	6,072	-----	-----
DRG 438	2,627	22.22	11.78	3,536	4,982	-----	-----

Table E8. Dollar and percent differences between VA costs and non-VA charges, reimbursements, or costs for the psychiatric DRGs producing the greatest number of discharges in Major Diagnostic Categories 19 and 20.

	Difference between VA Costs & Non-VA Charges		Difference between VA Costs & Non-VA Reimbursements		Difference Between VA Costs & Non-VA Costs	
	Dollar Difference ($)	Percent Difference (%)	Dollar Difference ($)	Percent Difference (%)	Dollar Difference ($)	Percent Difference (%)
HCFA PPS						
DRG 430	378	10.54	789	22.00	-----	-----
DRG 438	(291)	-12.05	347	14.37	-----	-----
HCFA non-PPS						
DRG 430	(798)	-19.56	453	11.11	-----	-----
DRG 438	(681)	-24.63	14	0.51	-----	-----
Utah Medicaid						
DRG 430	880	17.96	2,098	42.82	-----	-----
DRG 438	1,767	54.24	1,914	58.75	-----	-----
Maryland						
DRG 430	13	0.31	-----	-----	442	10.56
DRG 438	(417)	-16.67	-----	-----	(72)	-2.88
NE Teaching Hospital						
DRG 430	-----	-----	-----	-----	(3,852)	-105.82
DRG 438	-----	-----	-----	-----	(1,850)	-71.98
California						
DRG 430	(1,555)	-34.43	-----	-----	-----	-----
DRG 438	(1,446)	-40.89	-----	-----	-----	-----

January 9, 1989

John A. Gronvall, M.D.
Chief Medical Director
Veterans' Administration
810 Vermont Avenue NW
Washington, D. C. 20420

Dear Dr. Gronvall:

As you know, the Conference Report accompanying the fiscal year 1989 appropriation for the Veterans' Administration indicated that the amount of funding for the Department of Medicine and Surgery is specifically intended to support 194,720 FTEE.

Assuming that the same FTEE level will be indicated for the fiscal year 1990 budget, please provide for the Committee's information the personal services funding level that would be required to support 194,720 FTEE for fiscal year 1990. We understand that the delivery of medical services includes costs beyond personal services. Please provide for the Committee the funding levels in other accounts for fiscal year 1990 that would be commensurate with an FTEE level of 194,720.

Thank you for your help in providing this information. Your earliest response would be very much appreciated.

Sincerely yours,

G. V. (SONNY) MONTGOMERY
Chairman

GVM:vbd

Department of Medicine and Surgery **Washington D.C. 20420**

Veterans Administration

In Reply Refer To: 10A22

Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to respond to your January 9, 1989 letter requesting the level of resources necessary to support 194,720 FTEE and maintain a balanced medical care program during FY 1990.

Since the FY 1989 President's Budget was submitted to Congress in February 1988, numerous events have occurred requiring funding from the Medical Care Appropriation. These events include, among others, the passage of P.L. 100-322, "Veterans Benefits and Services Act of 1988"; a payraise increase from 2 to 4.1 percent; a Federal employee health benefit increase; increased demands for employee special salary rates; and an escalation in the number of veteran AIDS patients.

The FY 1989 estimate in the FY 1990 President's Budget reflects the levels of care (workload) and employment affordable at the appropriated level of resources. Within the total dollars available, resources were realigned to effect a balanced health care program. This realignment included shifting capital investment dollars to personal services to help maintain employment levels and the combining of Community Nursing and Contract Hospital program resources to maximize the use of VA supported contract program funding.

The following chart summarizes the projected 1989 workload (for VA hospital treatments and outpatient staff visits) and the funded workload levels that are reflected in the FY 1989 estimate for the FY 1990 President's Budget.

	TOTAL MEDICAL CARE FTEE	VA HOSPITAL PATIENTS TREATED	OUTPATIENT VISITS
FY 1989 Estimate (Projected levels).................	194,720	1,096,509	22,865,000
FY 1989 latest Estimate (Supportable level)......	190,077	1,096,509	20,452,000
Difference.................	-4,643	...	-2,413,000

Current VA medical center operating plans for fiscal year 1989 reflect a reduction of outpatient visits while inpatient workloads remain stable. The FY 1990 President's Budget proposes a more permanent re-distribution of workload. FY 1989 operating shortfalls currently estimated at $614 million make it impossible to support 194,720 FTEE and 1988 workload levels. The House Appropriations Committee staff have also requested an estimate of the additional resources necessary to end fiscal year 1989 at a level of 194,720 positions. A copy of that analysis is included for informational purposes (Enclosure A). Without supplemental support in FY 1989, Medical Care employment is expected to decline to approximately 186,000 FTEE by year's end, representing a cumulative FTEE level of 190,077.

Funding levels necessary to support 194,720 FTEE and maintain a balanced program including personal services and "all other" operating costs in FY 1990 are in Enclosure B.

In developing necessary FY 1990 resource requirements, the FY 1989 appropriation level was used as a base. FY 1989 supplemental requirements and uncontrollable FY 1990 current service items such as payroll, inflation, and facility activations, have been added. A one percent productivity improvement and an FY 1990 payraise of two percent are assumed.

In addition, program and management initiatives currently included in the President's FY 1990 budget have been included with the exception of the redistribution of levels of care (workload adjustment) and procurement savings initiatives. The net program increase of 30 FTEE and $4.1 million will support many automation efforts as well as clinical initiatives including AIDS treatment and Post Traumatic Stress Disorder (PTSD) programs requiring, in total, 194,948 FTEE. An adjustment of 128 FTEE and $4.6 million is necessary to reduce the level to the 194,720 FTEE referenced in your request.

The net of these changes would result in a level for Medical Care (based on existing legislation) in FY 1990 of $11.5 billion to support a balanced program including 194,720 FTEE. This is $796.9 million above the FY 1990 President's request of $10.771 billion, and $995.7 million above the 1989 appropriation level of $10.5 billion. These resources would support additional workload as follows:

	1990 PRESIDENT'S BUDGET	1990 REVISED PROJECTION	CHANGE
Total FTEE................	186,194	194,720	+ 8,526
VA Hospital Pats. Trtd....	1,078,993	1,099,877	+20,884
Outpatient Staff Visits (000)....................	21,277	22,956	+ 1,679
VA Domiciliary Pats. Trtd.	12,249	19,669	+ 7,420
Community Nursing Census..	7,260	10,709	+ 3,449

We hope this is responsive to your request.

Sincerely,

John A Gronvall

JOHN A. GRONVALL, M. D.

Enclosures

MEDICAL CARE
BUDGET AUTHORITY ANALYSIS
RESOURCES REQUIRED TO MAINTAIN BALANCED PROGRAM

ENCLOSURE A

ITEM	1989			
	ASSUMING SUPP.RELIEF ON APRIL 1		ASSUMING SUPP.RELIEF ON JUNE 1	
	FTEE	$(000)	FTEE	$(000)
1989 PRESIDENT'S BUDGET....	192,358	$10,327,546	192,358	$10,327,546
Congressional Action.......	2,362	$215,000	2,362	$215,000
APPROPRIATION..............	194,720	$10,542,546	194,720	$10,542,546
LESS: UNFUNDED FTEE('89 Mid.Col)	(4,643)	...	(4,643)	...
1989 MIDDLE COLUMN ESTIMATE	190,077	$10,542,546	190,077	$10,542,546
VA SUPPLEMENTAL REQUIREMENTS:				
Payraise.................	...	$86,065	...	$86,065
FEHB.....................	...	$61,154	...	$61,154
Within-Grades (1989).....	...	$58,907	...	$58,907
Special Pay..............	...	$74,998	...	$74,998
Saturday Premium Pay.....	...	$19,400	...	$19,400
Outpatient Eligibility Chg	383	$21,054	383	$21,054
Standardization Med.Items	3	$112	3	$112
Info & Training/AIDS.....	...	$7,130	...	$7,130
AIDS/Univ. Precautions...	...	$25,810	...	$25,810
Restrictive Approp. Lang.	...	$12,000	...	$12,000
State Home Per diem......	...	$14,731	...	$14,731
Tuition Reimbursement....	...	$5,000	...	$5,000
Health Care Outside U.S..	...	$660	...	$660
POW Dental care..........	...	$279	...	$279
Beneficiary Travel.......	...	$43,298	...	$43,298
Report on Contract care..	...	$1,500	...	$1,500
Employment Restored......	4,643	...	4,643	...
Subtot.VA Supplemental Require	5,029	$432,098	5,029	$432,098
SUPPLEMENTAL ADJUSTMENTS:				
Beneficiary Travel.......	...	($18,298)	...	($18,298)
State Home Per Diem......	...	($4,612)	...	($4,612)
FEHB.....................	...	($3,578)	...	($3,578)
Special Pay..............	...	$5,692	...	$5,692
Requirement to support Non-VA Workload in 1989....	...	$23,770	...	$23,770
Subtot.Adjust.to Suppl.Require	...	$2,974	...	$2,974
TOTAL SUPPLEMENTAL REQUIREMENTS	5,029	$435,072	5,029	$435,072
MID.COLUMN EST. + SUPPLEMENTAL	195,106	$10,977,618	195,106	$10,977,618

Continued on following Page

ENCLOSURE A

MEDICAL CARE
BUDGET AUTHORITY ANALYSIS
RESOURCES REQUIRED TO MAINTAIN BALANCED PROGRAM

ITEM	1989			
	ASSUMING SUPP.RELIEF ON APRIL 1		ASSUMING SUPP.RELIEF ON JUNE 1	
	FTEE	$(000)	FTEE	$(000)
ADJUSTMENTS REQUIRED TO MEET PAUL THOMSON REQUEST:				
SUPPLEMENTAL ITEMS REDUCED TO MEET 194,720 FTEE LEVEL:				
Outpat. Eligibility Chg	(383)	($21,054)	(383)	($21,054)
Standardization Med.Items	(3)	($112)	(3)	($112)
DELAYED RECEIPT OF SUPPLEMENTAL/ FTEE NOT SUPPORTED IN REACHING 194,720 END POINT EMPLOYMENT	(2,090)	($73,781)	(2,980)	($105,200)
REVISED 1989 ESTIMATE......	192,630	$10,882,671	191,740	$10,851,252
DOLLAR INCREASE ABOVE APPROPRIATION		$340,125		$308,706

ENCLOSURE B

MEDICAL CARE
BUDGET AUTHORITY ANALYSIS
RESOURCES REQUIRED TO MAINTAIN BALANCED PROGRAM

ITEM	1990	
	FTEE	$(000)
1989 PRESIDENT'S BUDGET....	192,358	$10,327,546
Congressional Action.......	2,362	$215,000
APPROPRIATION..............	194,720	$10,542,546
SUPPLEMENTALS:		
State Home Per Diem Incr.	...	$14,731
Tuition Reimbursement....	...	$5,000
Outpatnt Eligiblty Change	383	$21,054
Health Care Outside U.S..	...	$660
POW Dental Care..........	...	$279
Beneficiary Travel.......	...	$43,298
Report on Contract Care..	...	$1,500
Saturday Premium Pay.....	...	$19,400
Standardization Med Items	3	$112
Info & Training/AIDS.....	...	$7,130
AIDS/Univ. Precautions...	...	$25,810
Restrictive Approp. Lang.	...	$12,000
Payroll..................	...	$281,124
Subtotal...............	386	$432,098
APPROPRIATION, ADJUSTED....	195,106	$10,974,644
1990 CURRENT SVC. CHANGE:		
PAYROLL:		
FECF..................	...	$6,277
Within-Grades.........	...	$52,373
Stipend...............	...	$9,673
Social Security.......	...	$16,851
Medicare..............	...	$304
FERS..................	...	$23,785
1989 Pay Annualiztn....	...	$74,302
1989 FEHB.............	...	$15,854
Subtotal............	...	$199,419
INFLATION...............	...	$217,523
STATE HOME PER DIEM INCR.	...	$6,460
FACILITY ACTIVATIONS:		
Total Request...........	2,177	$289,505
Less 89 Non-Recurng Base	...	($110,186)
Subtotal............	2,177	$179,319
CAPITAL INVESTMENT:		
Less 89 Computer Systems	...	($44,701)
Replace Equip (Obj 31)..	...	$40,498
Subtotal............	...	($4,203)

MEDICAL CARE
BUDGET AUTHORITY ANALYSIS
RESOURCES REQUIRED TO MAINTAIN BALANCED PROGRAM

ENCLOSURE B

	1990	
ITEM	FTEE	$(000)
UNCONTROLLABLE WRKLD CHG:		
State Home.............	...	$9,181
Subtotal.............	...	$9,181
MISCELLANEOUS:		
NSEP..................	...	($168)
Real Property Rental...	...	$3,283
Nursing Realignment....	+/-586	+/-$23,593
Postage Increase.......	...	$2,150
Reimbursable Payments..	227	$500
Subtotal.............	227	$5,765
1989 SUPPL ANNUALIZED:		
POW Dental Care..........	...	$34
Report on Contract Care..	...	($1,500)
Saturday Premium Pay.....	...	$400
Info & Training/AIDS.....	...	($7,130)
AIDS/Univ. Precautions...	...	($25,810)
Restrictive Approp. Lang.	...	($12,000)
Special Pay (Payroll)....	...	($19,790)
	...	($65,796)
A-76 Privatization.......	(730)	($5,236)
Tot.VA Cur.Svc.Req.Incr..	1,674	$542,432
VA CURRENT SVC. REQUEST....	196,780	$11,517,076
ADJUSTMENTS TO CUR.SVC.:		
Supplemental Adjustments:		
Beneficiary Travel.....	...	($18,298)
State Home Per diem....	...	($4,612)
FEHB..................	...	($3,578)
Special Pay............	...	$5,692
Tot.Suppl.Adjustments..	...	($20,796)
Supplemental Annualization Adj:		
Info & Training/AIDS...	...	$7,130
AIDS/Univ. Precautions:		
Annl. Above..........	...	$25,810
Incl.in Request Initiative	...	($13,000)
Tot.Suppl.Annl.Adjust..	...	-$19,940

MEDICAL CARE ENCLOSURE 8

BUDGET AUTHORITY ANALYSIS
RESOURCES REQUIRED TO MAINTAIN BALANCED PROGRAM

ITEM	1990	
	FTEE	$(000)
One Percent Productivity.	(1,962)	($68,684)
1990 Payraise (2%) Assumption..................	...	91,246
VA CURRENT SERVICE REQUIREMENT	194,818	$11,538,782
REQUEST LEVEL INITIATIVES:		
VA Bed Conversions........	+/- 468	+/-$18,820
PTSD Programs............	40	$1,695
DHCP-Implementation......	...	$18,570
-VAMC Savings.........	(659)	($36,208)
PAID Redesign-Implement..	...	$4,799
-VAMC Savings.........	(43)	($878)
ISMS- Implementation.....	...	$704
-VAMC Savings.........	...	($4,100)
VALOR Program............	112	$1,813
Drug Testing Program.....	...	$733
Replacement Equip(Obj 31)	...	($39,000)
CALM Savings.............	...	($40)
Centralizd Aquistn & Dist	...	($3,600)
Procurement Savings......	...	($50,000)
Prosthetic Centr Transfer	(45)	($1,485)
AIDS Clinical Programs...	625	$61,635
1990 M/PIPS with $:		
Occupational Injury......	...	($302)
CHAMPVA Payment Center...	...	($223)
Total Budget Initiatives.	30	($45,887)
Adjust. to Budgeted Init:		
Procurement Savings....	...	50,000
Total Budget Initiatives.	30	$4,113
SUBTOTAL REQUIREMENTS......	194,848	$11,542,895
ADJUSTMENT TO 194,720 FTEE.	(128)	(4,610)
TOTAL AT 194,720 FTEE......	194,720	$11,538,285
1990 PRESIDENT'S BUD.,EXIST.LEG.	186,194	10,741,431
NEEDED IN 1990 TO MEET THE 194,720 FTEE WITH A BALANCED PROGRAM.......	8,526	$796,854
OBJECT DISTRIBUTION:		
Personal Services........	8,526	$441,851
Equipment................	...	$82,722
All Other................	...	$272,281

MEDICAL DISTRICT 16

~~5000 West National Ave.~~
Milwaukee WI 53295

Veterans
Administration

December 22, 1988

In Reply Refer To:
695/MD16

Mr. Paul Trigleth
County Veterans Service Officer
Courthouse
515 Oak Street
Baraboo, WI 53913

RECEIVED
[illegible] 1988
SAUK COUNTY VETERAN
SERVICE OFFICE

Dear Mr. Trigleth:

1. Significant changes affecting delivery of health care at VA Medical Centers were recently enacted as part of Public Law 100-322, "The Veterans Benefits and Services Act of 1988." Due to limited resources, it will be necessary to limit health care to some veterans, as prescribed by this law. While this is an issue of concern across the entire VA health care system, this letter is intended to explain the impact of this action to those veterans served by the VA Medical Centers (Iron Mountain, Madison, Milwaukee and Tomah), Medical District 16.

2. As you may be aware, the VA has used a categorization system (Means Test) to determine eligibility for care. The categories associated with this system and what they represent are as follows:

CATEGORY "A" - Exempt from Means Test

*Service Connected veterans
*Veterans of World War I, the Mexican Border Period and the Spanish-American War
*Former Prisoners of War
*Veterans in receipt of a VA Pension
*Veterans who claim exposure to Agent Orange or Ionizing Radiation
*Veterans eligible for Medicaid
*Veterans not in the above classifications whose income does not exceed $16,466 (for single veterans), $19,759 (for veterans with one dependent), [if more than one dependent, add $1,098 for each additional dependent], or whose annual income plus net assets are less than $40,000.

CATEGORY "B"

*Non-Service Connected veterans whose annual income does not exceed $21,954 (for single veterans), $27,441 (for veterans with one dependent), [add $1,098 for each additional dependent], or whose annual income plus net assets are less than $40,000.

CATEGORY "C"

*Veterans whose income exceeds the Category B levels, or whose annual income plus net assets are greater than $40,000

[NOTE: The above income levels are effective January 1, 1989 and subject to change annually on January 1.]

INPATIENT CARE

Category A - There will be no change in the provision of inpatient care.

Category B & C - Veterans in need of emergency care will receive such care. Veterans in Category B who require non-emergent care may be provided inpatient care. Category C veterans requiring non-emergent inpatient care will be asked to seek community care not at VA expense. Those Category B & C veterans who are admitted will normally receive only one (1) outpatient followup visit and a minimal supply of medications upon discharge.

OUTPATIENT CARE

Category A - There will be no change in the provision of outpatient care.

Category B & C - Category B & C veterans applying for care who are in need of outpatient services (not admission) will receive an initial evaluation and minimal medications. They will not be placed in an outpatient program or scheduled for continued care. Category B & C veterans currently on the outpatient rolls will be evaluated by each of their VA physicians at their next outpatient visit in each clinic; the physician may make the decision to discharge the veteran from outpatient care for that specific condition. When discharged from the clinic, the veteran will be given a minimal supply of medications if ordered by the physician. These veterans will be requested to make alternate arrangements for their future care.

CONTRACT NURSING HOME CARE

Non-Service connected veterans requiring nursing home care following a period of hospitalization may continue to be placed in a community Nursing Home at VA expense; however, placements at VA expense will be limited to a maximum of 90 days.

MILITARY RETIREES

Military retirees seeking health care will be provided care as veterans in accordance with the above-stated criteria.

INPATIENT AND OUTPATIENT DENTAL CARE

Inpatient and outpatient dental care will continue to be provided only as required by law.

FEE BASIS MEDICAL CARE (Provided Away from VA Medical Centers by non-VA Providers)

Fee medical care will continue to be authorized when deemed to be medically necessary. Drugs, when prescribed by the patient's physician, must be mailed to the VA for filling after the initial one-month supply is filled by a local pharmacy. Patients receiving oxygen from the VA will be reviewed for possible alternative funding support outside the VA.

3. The emphasis on quality of care rendered is very important and must be maintained. The actions described above are internal adjustments being made to accommodate the current budget situation. Your cooperation and understanding is requested. VA staff will be available to assist patients in their transition to community care. Working together, we will continue to provide quality patient care to the greatest number of veterans. You will be informed of any other changes in access to health care and services provided by the VA Medical Centers, Medical District 16.

4. Eligibility questions may be referred to the Chief, Medical Administration Service, at the appropriate VAMC.

Sincerely yours,

R.E. STRUBLE
District Director
Medical District 16

THE NEED IS NOW

AN INDEPENDENT BUDGET BY VETERANS
FOR VETERANS' PROGRAMS

JANUARY 1989

PROLOGUE

This budget proposal is respectfully submitted to the Congress, which, over past years, has labored hard and long to provide an adequate budget for veterans' programs. This document, covering the main issues in the Veterans Administration Annual Budget, is the product of a combined effort of four major Congressionally Chartered Veterans' Service Organizations. This collaborative effort connotes a final loss of confidence in OMB's intention or ability to address veterans' issues objectively or to support the moral and legal obligations that this nation has accorded the men and women who have served our country.

The serious erosion of the discretionary components of the Veterans Administration budget are of primary concern to the authors of this document. Veterans, who have given of themselves in defense of our country and for the continued assurance of the liberty and security of their fellow citizens, surely have earned top priority for their benefits--equal to, if not greater than, the recipients of any other federally sponsored socioeconomic or health care program. Veterans benefits must enjoy the same protection as that accorded to social security recipients.

Jimmy T. Smith
National Commander
American Veterans of World
War II, Korea and Vietnam

Billy E. Kirby

Billy E. Kirby
National Commander
Disabled American Veterans

John H. Michaels
National President
Paralyzed Veterans of America

Larry W. Rivers
Commander-in-Chief
Veterans of Foreign Wars
of the United States

ENDORSEMENTS

American Association of Spinal Cord Injury Nurses

American Association of Spinal Cord Injury Psychologists and Social Workers

American Federation of Government Employees

American Nurses Association

American Paralysis Association

American Paraplegia Society

Association of American Medical Colleges

Blinded Veterans Association

Jewish War Veterans

Legion of Honor

Military Order of the Purple Heart

National Association of VA Physicians

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INTRODUCTION

For the past two years, four Congressionally chartered Veterans Service Organizations (VSOs) have joined in a cooperative effort to develop and present to Congress a budget proposal addressing the program requirements of the Veterans Administration (VA). We are again this year taking this proactive approach to place on the record the perspective of the Congressionally chartered consumer representatives of our nation's veterans, independent of what we consider the flawed budget process of the Office of Management and Budget (OMB).

The Independent Budgets (IB) have been well received in Congress and the VSOs are particularly gratified that last year's submission was considered an effective counterpoint to the Administration's FY 1989 budget request. The Veterans Affairs Committees of the Congress have stated that they need and want the VSOs to continue to prepare and submit an Independent VA Budget.

During its short history, the Independent Budget has become an integral part of the VA budgetary legislative process. The VSOs are, of course, encouraged by the Congressional response, but also recognize that the Independent Budget is so essential because the Administration's budget requests have lost their credibility.

The 1989 Independent Budget identified major problems in the delivery of service to veterans and articulated the premise that, to a great extent, the Administration's budget process was responsible for those problems. The underlying theme of the 1989 Independent Budget was that the Administration's budget proposals did not reflect a realistic assessment of the problems now facing veterans. This makes it virtually impossible for VA personnel, responsible for delivering services to veterans, to provide cost-effective solutions to those problems.

The 1989 IB provided a detailed analysis of the state of each program administered by the VA and assessed its effectiveness in terms of the VA's ability to provide the level of service to veterans intended by Congress with the then current funding. This analysis established that there has been continuing deterioration in resources to provide the quality and timeliness of service to veterans by the VA and that this deterioration was linked directly to the budget construction process. Equally disturbing was the obvious presence of a generalized demoralization of VA personnel caused by OMB's arbitrary budget cuts.

The 1989 IB made a number of recommendations which were designed to reverse the trend of declining service and provide an environment within the VA where past levels of service could be restored. In making these recommendations, the VSOs were fully mindful of the climate of budget austerity; therefore the recommendations required only a minimal percentage increase in funding. Because they were not funded, some are presented again this year along with other initiatives to improve the quality and timeliness of service by providing VA personnel with resources that realistically could be expected to increase their productivity and job knowledge, not only in the immediate future, but more importantly for the long-term as well. This, the VSOs believe, is what the budget process should be about--providing the best possible services with the least possible resources.

The VSOs are equally aware this year that fiscal constraints on the federal budget must continue. We have repeatedly assured Congress of VSOs willingness to accept decrements in veterans' program funding providing those cuts are equitably applied to all other programs. Where discriminatory budget cuts are made, they must surely be based on valid priorities. Veterans, who have given of themselves in defense of their country and for the continued assurance of the liberty and security of their fellow citizens, surely have earned top priority for their benefits--equal to, if not greater than the recipients of any other federally sponsored socioeconomic or health care program. Veterans benefits must be protected in the same way benefits for social security recipients are protected by the Administration.

We have taken care, in the development of this document, to exercise responsibility and restraint. All recommendations are based on measured need. We hope those needs can somehow be met.

The traditional and proper role of the Executive Branch agency is to provide Congress with accurate data on the amount of appropriations that are necessary, given effective management and employee efficiency, to provide no less than adequate service to veterans in accordance with Congressionally directed programs. The Congress needs this type of budget formulation to appropriate funds wisely and responsibly. If funds are simply not available to provide this level of service, even with reasonable productivity improvements, Congressional decisions must be made, after expert input from the VA, on where budget cuts will have the least negative impact on veterans.

It is agonizingly clear to the VSOs that this commonly accepted and rational approach to budget making has been turned on its head by the OMB. Budget cuts are predetermined and made in the vacuum of the insular world of numbers. Budget formulation by VA managers reflecting their real needs in providing service to veterans has become a futile exercise. Their voice falls on deaf ears at OMB. Because needs are too often ignored or obfuscated by OMB in their final budget document, Congress is deprived of this essential input. The result is a budget process that is divorced from reality because it has little relationship to the real needs of real people. The process feeds on itself, becoming even more detached from the real world when the Administration attempts to justify it. Thus, when confronted with the litany of facts which demonstrate grossly inadequate service due to grossly inadequate resources, the Administration states the false promise that funds requested are sufficient to provide adequate service; this leads to the equally false conclusion that the level of service to veterans must, therefore, be adequate. This flawed process has become so entrenched that decisive action must be taken to break the vicious circle.

In this FY 1990 Independent Budget, we document the sorry state of service to veterans with more than statistics. We describe actual results affecting real people which have been caused by the erosion of the VA resource base. Most glaring, perhaps, is the admitted denial of needed medical care to eligible veterans and the deteriorating quality of care accorded others.

Last year's Independent Budget not only voiced the concerns of veterans, it also incorporated the concerns of VA managers and employees with the budget process--whose concerns are otherwise muted. The VSOs have every confidence that VA employees have the talent, information, dedication and motivation to provide the quantity, quality and timely service which veterans deserve, given adequate resources. Their frustration, however, must be as great as that of the VSOs because not only have they not been provided with the tools necessary to do their jobs, they lack the means to obtain them through an obviously flawed budget process. The VSOs, therefore, feel compelled to speak for them.

The urgency of the FY 1990 Independent Budget cannot be overstated. By any standard, service to veterans is at an all-time low. Given the current situation, the VSOs believe that a fundamental change in the budget--making process must occur if this situation is to be corrected. The VSOs take satisfaction in Congress becoming more directly involved in the assessment of VA staffing and resource needs and also directing that essential management initiatives be implemented.

However, the FY 1989 Administration budget proposal, with its woefully inadequate appropriations request for the delivery of essential service to veterans, was the continuation of a long-term practice of unrealistic budget submissions. The problem is that the existing process does not take into account the cumulative damage inflicted upon veterans by a series of ill-advised budget requests.

Rather, each year's request is considered separately with current services being defined by adding funds for some, but not all, uncontrollable new expenses to the eroded resource baseline of the previous year. The shortfall is then compounded by further purely arbitrary cuts. The fact is, however, that even if proposed cuts are not accepted by Congress, the basic problem is nonetheless perpetuated because a continuation of an ever diminishing "current service" level can only result in further service deterioration. Yet another year in this vicious cycle will be nothing short of disastrous.

For these reasons, it has become increasingly important that Congress be more directly informed in the particulars of the VA budget. The fundamental question is the level of appropriations actually needed to deliver an adequate level of service to veterans and their families, irrespective of OMB's unrealistic budget request.

As before, the format of this document generally follows that of the official federal budget of the

Veterans Administration. We deal only with accounts for which VA appropriations are required, not with those that are self-financed or financed by other agencies. The text in each broad budget component contains a list of principles and guidelines, statements of the challenges facing the VA, our strategy to address those challenges, and our specific recommendations. Insofar as possible, we have eliminated "boilerplate" verbiage, but we make use of narrative material to explain programs and policies. Legislative proposals described in this document are being separately submitted. All policies and recommendations in this Independent Budget have the unanimous concurrence of all participating Veterans Service Organizations.

We are appreciative of the VA's helpful response to our Freedom of Information request for management data in the public domain. It has enabled us to conduct independent analyses of VA programs and utilization trends, better identify veterans' needs and make informed judgments regarding the administration of medical and other benefits programs, and VA construction. Information on which the views and recommendations contained in this document are based was not, however, limited to VA reports. Information from other federal and private sources and studies was also used. In addition, we undertook systematic, in-depth discussions with top management in VA regional offices and medical centers, and incorporated feedback from veteran constituents.

The VA program managers and providers of veterans' services, be it health care or other benefits, are to be commended for functioning as well as they do under the very trying circumstances stemming from short staffing and short funding.

The Congressionally Chartered Veterans Service Organizations respectfully submit this fiscal year 1990 Independent Budget proposal for Congressional consideration and look forward to providing further testimony on its behalf.

PRINCIPLES AND GUIDELINES FOR BUDGET FORMULATION

The Congressionally chartered veterans service organizations that developed this Independent Budget are committed to an objective and responsible approach to this, our "veterans' budget for veterans." We have therefore compiled a set of principles for guidance in budget formulation. These include both general principles that apply to the whole Veterans Administration budget and other principles that are identified with major budget components. All are a reflection of our mutually shared underlying philosophy regarding veterans' programs. The principles for the entire budget are presented here; those specific to major budget components are presented in the corresponding sections of this Independent Budget.

1. Productivity improvements should not be arbitrarily anticipated in the budget process. Rather, they should only be budgeted based on specifically demonstrated and identified management initiatives that result in actual productivity increases.

2. Payroll cost increases necessary to maintain the FTEE ceiling established in appropriation language should be allowed as a prospective estimate in the budget for the fiscal year in which these increases are anticipated. This would permit the complete and most effective utilization of the FTEE ceiling made available to the VA.

3. There should be no discriminatory denial of Cost of Living Allowances (COLA). The VSO authors of the Independent Budget have assured Congress of their support in any reduction or elimination of a COLA increase, providing it is applied across the board, involving all federal agencies and accounts.

4. Training and continuing education of VA staff is vital. Total resources for continuing education of health care professionals should be reinstated as a budget line item and more adequately funded. The budget should fully support medical education and include the continuation of professional scholarships to improve recruitment and retention of health care professionals in the VA system. Similarly, adequate funding should be provided for training necessary to assure adequate numbers of competent adjudication officers, counselors, claim processors, and other administrative personnel to effectively manage veterans' benefits programs.

5. VA facilities should be sited and staffed to serve veterans in the areas of the country in which veterans live. For both health care facilities and regional offices, this means a geographic realignment paralleling the major population shift of veterans to the "Sun Belt". The realignment may require new facilities as well as expansion of existing ones and geographic realignment of staff. For cemeteries this means a National Cemetery in every state.

6. The VA should swiftly develop integrated automated data process (ADP) systems to provide the data flows among its component departments (and with other federal agencies) needed to provide veterans timely service in meeting their needs. The absence of integration of ADP systems between VA departments is notable and an important cause of deficient service.

THE BUDGET IN BRIEF

This is a veterans' budget for veterans developed by four major Congressionally Chartered Veterans Service Organizations (VSOs): American Veterans of World War II, Korea and Vietnam (AMVETS), the Disabled American Veterans (DAV), the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW). In this budget, we have been both fiscally prudent in our recommendations and responsive to veterans' real needs in our proposals.

THE CHALLENGE

Three principal challenges shape our budget this year. One is the increasing demand on VA programs that stems from the aging of the veteran population. The largest group of veterans, the World War II and Korean War generations, is now rapidly reaching age 65 and over--ages at which health care needs and death rates increase dramatically. This aging process, the first challenge, results in a need for more services from the VA's health care system and from its cemetery and memorial affairs programs.

The second challenge facing the Independent Budget is to reverse the progressive erosion of the resources necessary to provide veterans their earned benefits. We find that over the past several years this erosion has been a common administration response to veterans and has now reached crisis proportions in all general program areas. While the erosion of the resource base associated with veterans programs is having a severe negative impact on the ability of veterans to receive these benefits in a timely and qualitative manner, this erosion, which has occurred over several years, now presents a need for vastly improved funding to meet program requirements. In medical care, this underfunding is causing severe cutbacks in several program areas which in turn is threatening quality of care and the ability of the VA to optimally support its affiliation program.

The third challenge is that of veterans' unmet need for VA services. Unmet need appears in the Veterans' benefit area, where severe deficiencies are found in services provided to veterans; these result primarily from understaffing of the Department of Veterans Benefits (DVB), the VA unit that administers benefits programs. We have also found evidence of multiple types of veteran unmet health care needs across the VA system.

OUR STRATEGY

The basic strategy of the Veterans Service Organizations that have authored this Independent Budget is:

> To assure that all veterans receive the benefits and services to which they are entitled;
>
> To assure that the VA provides benefits and services in a manner that is cost-efficient and timely;
>
> To assure the integrity, quality, and appropriate integration of the benefits and services the VA provides; and
>
> To pursue the establishment of a more exact and rigorous budget formulation process to assure that Congress recognizes the need for and appropriates the funds necessary to support legislated programs/benefits.

In light of the need for austerity, an important component of our strategy consists of confining our initiatives to actions dealing with veterans' most urgent needs, and proposing to meet these needs in the most economical fashion possible.

On the other hand, the shortfalls in funding that have accumulated over the past several years must be eliminated before permanent irreparable damage occurs to veterans' benefits. This brings about the need for a considerable infusion of funds in this period of budget austerity.

Our overall strategy recognizes that total veteran benefit program costs increase less rapidly than does inflation because of the declining number of program beneficiaries in the largest benefits programs (compensation and pensions). All such savings should be regarded as available to meet the growing need for health care services that arises as the veteran population continues to age.

In the benefits administration area, our strategy is directed primarily at improving the service the VA is providing. We seek service in the adjudication of claims that measures up to standards of timeliness and quality of the late 1970s, as well as comparable improvements in other important service areas. This will require (1) an increase in staff; (2) the installation of appropriate computer systems in the VA and their integration across departments of the VA; and (3) the establishment of needs-directed training programs that will develop, maintain, and upgrade the skills of the benefits program staff.

Veterans are willing to shoulder their share of the burden of deficit reduction. We will thus accept a curtailed cost-of-living adjustment (COLA) in 1990 in veterans' benefits programs if all other federal program beneficiaries--including Social Security recipients--do likewise and if there is a similar curtailment of federal contract cost increases due to COLAs in contractor employees' wages. Otherwise, we call for a full and equitable COLA increase in veterans' benefits programs. Our strategy for benefits also calls for putting the loan guaranty program on a sound financial footing as a VA-operated program.

In the medical programs area, our strategy is to attack current problems of unmet need and to meet growing need in the future by increasing our emphasis on less expensive care modalities. In particular, our recommendation is for more reliance on non-institutional forms of care, which are generally far more economical than are institutional modalities of care. The VA has recently achieved impressive shifts toward non-institutional care in the mix of care it delivers, and our strategy calls for still further shifts in this direction. And, in order to provide quality care to our veterans, the VA must use state-of-the-art equipment, and adequately staff VA facilities. To keep the health care system functioning at an acceptable level will require additional funds just to eliminate serious shortages that now exist and to preclude such shortfalls in future years.

Our strategy in Medical and Prosthetic Research is to reestablish and maintain a more adequate, stable and assured resource capability to halt the VA's deteriorating ability to fund high quality research proposals.

Our primary strategy in Medical Administration is to plead for the MAMOE budget the necessary resources and program authority to meet the imperative of protecting, in all of its ramifications, the access to and quality of VA health care.

Our strategy in VA construction starts with the necessity of maintaining the system of VA health care facilities, assuring that they are in good repair, and that functional space is updated to keep up with changes in health care delivery technology and needs. In addition, we call for the development of a system that will realistically assess the need for construction and include a sound system for setting construction priorities. Our strategy also calls for an expansion of the National Cemetery System to make burial plots available in reasonable proximity to veterans' families.

GENERAL RECOMMENDATIONS

Tables 1 and 2 show the funding we recommend in the appropriation accounts into which the VA budget is divided. These tables show that most of the increase we recommend is required merely to keep even with rising costs. This has not occurred in the past and is evidenced in the large increases shown for current services.

Total appropriations for the VA in FY 1988 were $28.3 billion. Just to maintain the same level of program activity in FY 1989 would require $29.7 billion. This concept of maintaining the same level of program activity as in FY 1988 is what we mean by "current services." The dollar increase from FY 1988 to FY 1989 needed to maintain current services (i.e., to maintain the FY 1987 level of services provided) is large--about five percent. Providing this increase is obligatory if the VA is to continue to provide the level of services in FY 1990 as was provided in FY 1988.

Unfortunately, as the tables show, the FY 1989 enacted appropriations total about $500 million dollars less than the FY 1989 current services level (i.e., less than the amount necessary to continue to provide the FY 1988 level of services). We call for appropriation of the additional amount needed to reach the current services level in FY 1989 so that the VA can continue to provide the services it has offered in the past. If these additional funds are not appropriated, a considerable cutback in medical care, medical research, and in grants to states for extended care facilities will be required. Further, there will accrue an enormous backlog of applications for various veterans benefits that will not be processed for lack of staff.

In turn, the FY 1990 current services level is $31.3 billion, about $1.6 billion above the FY 1989 current services level. The 1.6 billion increase must be funded just to allow the VA to continue to operate in FY 1990 as it did in FY 1988.

As part of our computation of the current services level, we include amounts necessary to cover pay raises, and we are recommending these amounts be appropriated in full, at the beginning of each fiscal year--not late and not partial, as has too often been the case in the past, resulting in staffing cuts and corresponding reductions in needed services for veterans.

Our total recommended VA appropriation level for FY 1990 is $32.1 billion, about $800 million above the FY 1990 current services level. Thus, as is fitting in an era of austerity, most of the funding increase we recommend is required merely to cover increasing costs, not to support new initiatives. Our major recommendations for FY 1990--including managerial recommendations with relatively small budget impact--follow.

RECOMMENDATIONS FOR GENERAL OPERATING EXPENSES - BENEFITS ADMINISTRATION

Because service to veterans has worsened from already unacceptable levels with existing DVB resources and there is every indication that deterioration of service is accelerating, there is a critical need for the additional resources recommended in the FY 1989 Independent Budget. Supplemental appropriations for FY 1989 are therefore recommended for:

Increased staffing in areas of DVB where shortages are most critical, i.e., Veterans' Service Compensation, Pension and Education; Loan Guaranty; and Vocational Rehabilitation and Counseling. Increased staffing for FY 1990, in addition to the FY 1989 supplemental, is recommended for Compensation, Pension and Education.

Enhancement of DVB's existing automated systems while the VA proceeds with its promised, but delayed, integrated systems modernization plan.

Improved training for DVB employees, again concentrating on DVB functional areas in which training limitations have led to the most severe problems.

TABLE 1
VA APPROPRIATIONS SUMMARY
(dollars in thousands)

Appropriation Account	1988 Appropriation	1989 Appropriation	1989 IB Current Services*	1990 IB Current Services*	1990 IB Recommended Appropriation
General Operating Expenses and Misc.	774,810	783,320	830,460	873,960	910,160
Benefits Programs	16,571,300	17,063,670	17,123,670	17,497,400	17,497,400
Medical Programs	10,409,960	10,843,140	11,268,600	12,422,640	12,770,540
Construction Programs	522,900	500,640	501,540	502,540	921,920
TOTAL VA APPROPRIATION	28,278,970	29,190,770	29,724,270	31,296,540	32,100,020

*Funds necessary to maintain services at the FY 1988 level

TABLE 2
VA APPROPRIATIONS BY ACCOUNT
(dollars in thousands)

Appropriation Account	1988 Appropriation	1989 Appropriation	1989 IB Current Services*	1990 IB Current Services*	1990 IB Recommended Appropriation
GENERAL OPERATING EXPENSES AND MISCELLANEOUS					
General operating expenses	774,810	774,320	821,460	867,960	904,160
Grants for the construction of state veterans cemeteries	0	9,000	9,000	6,000	6,000
TOTAL GOE AND MISCELLANEOUS	774,810	783,320	830,480	873,960	910,160
BENEFITS PROGRAMS					
Compensation, pension, and burial benefits	14,832,400	15,460,600	15,460,600	15,685,600	15,685,600
Readjustment benefits	808,200	619,800	619,800	434,100	434,100
Veterans insurance and indemnities	14,300	13,470	13,470	13,900	13,900
Veterans'job training	0	0	60,000	0	0
Loan guaranty revolving fund	916,400	969,800	969,800	1,363,800	1,363,800
TOTAL BENEFITS PROGRAMS	16,571,300	17,063,670	17,123,670	17,497,400	17,497,400
MEDICAL PROGRAMS					
Medical Care	10,129,660	10,542,500	10,952,500	12,094,200	12,424,900
Medical and prosthetic research	192,900	210,240	224,700	235,000	249,200
Medical administration and miscellaneous operating expenses	46,600	47,900	48,900	50,940	53,940
Grants for Construction of State Extended Care Facilities	40,320	42,000	42,000	42,000	42,000
Grants to the Republic of the Philippines	480	500	500	500	500
TOTAL MEDICAL PROGRAMS	10,409,960	10,843,140	11,268,600	12,422,640	12,770,540
CONSTRUCTION PROGRAMS					
Construction, major projects	403,000	363,040	363,040	363,040	634,920
Construction, minor projects	116,000	111,600	112,500	113,500	275,000
Parking garage revolving funds	3,900	26,000	26,000	26,000	12,000
TOTAL CONSTRUCTION PROGRAMS	522,900	500,640	501,540	502,540	921,920
TOTAL APPROPRIATION	28,278,970	29,190,770	29,724,270	31,296,540	32,100,020

*Funds necessary to maintain services at the FY 1988 level

Direct the VA to complete the study ordered by Congress on a nationwide toll-free telephone service which should take into consideration the Social Security Administration's experience in implementing such a service.

Every support should be provided to ensure the continued integrity of the Veterans Loan Guaranty Revolving Fund.

We concur with the Administration's proposal that the Veterans Mortgage Life Insurance Program be funded within the Veterans Insurance and Indemnity Program rather than through Burial Benefits and Miscellaneous Assistance.

The VSOs suggest that it is particularly appropriate, now that the VA is to receive cabinet level status, to transfer to the VA all of the functions of the Department of Labor's Assistant Secretary for Veterans' Employment and Training.

RECOMMENDATIONS FOR BENEFITS PROGRAMS

Recommendations that will require more than nondiscretionary appropriations for benefit payments are:

A cost-of-living adjustment (COLA) effective December 1, 1989 in benefit programs that is equal to the COLA applied in other federal programs. The VSOs are prepared to support a reduced or delayed COLA as a deficit reduction method if it is applied across the board; and

A FY 1989 supplemental appropriation of $60 million for the Veterans' Job Training Program. Authority to fund $60 million for this account was provided for FY 1988 and FY 1989 through P.L. 100-322, which extended the program to September 30, 1989. However, appropriations to fund this legislation were not requested by the Administration.

The VSOs strongly support congressional efforts to provide long-term solutions to the problem confronting the Loan Guaranty Revolving Fund;

The VSOs support the Administration's proposal to fund the Veterans Mortgage Life Insurance program within the Veterans Insurance and Indemnities appropriation rather than through Burial Benefits and Miscellaneous Assistance; and

A proposal to consolidate all functions relating to veterans employment issues under the Department of Veterans Benefits rather than maintaining the current split responsibility for these functions between the Department of Labor and the Veterans Administration.

RECOMMENDATIONS FOR MEDICAL PROGRAMS

Fully fund cost increases necessary to assure current services are maintained at the FY 1988 level. Serious reductions in medical care will result in FY 1990 if further erosion of the resource base, as occurred in the FY 1989 budget, is not compensated for by replacement and annualization of the current dollar shortfall.

The specious OMB practice of exacting an annual 1 percent budget decrement for presumed personnel productivity improvement should no longer be tolerated by Congress.

There should be an end to OMB sub rosa budget reduction made via arbitrary and excessive assumption about the amount of expected slippage in facility activation dates. A more realistic slippage factor based on the last several years of actual experience must be applied.

While holding constant the targeted inpatient workload and in recognition of still further shift to more cost-efficient ambulatory care, 23.7 million outpatient visits should be anticipated for FY 1990.

The need is underscored to provide increasing additional funds to meet the VA's high cost of the growing AIDS epidemic.

The VA should not resort to a rationing of health care to veterans in order to operate within a budget shortfall. Supplemental budget requests in FY 1989 should precede such action.

We urge a more comprehensive survey, than any previously conducted, be designed and administered to a national sample of veterans for the purpose of identifying their health status, their health care needs, the source through which those needs are being met, their unmet medical needs and the potential the VA offers for meeting those unmet needs. Specifically, we recommend that the Institute of Medicine be solicited for a study proposal.

We again urge the Congress to expand outpatient care entitlement to all Category A veterans based on the same rules of access to health care as apply to in-patient treatment. It is time to eliminate the confusion and provide continuity of quality care to entitled veterans.

As requirements for veterans' benefits programs decrease with the aging of the veteran population, savings so derived should be regarded as funds available to meet their increasing health care needs.

We suggest Congress should request of the VA annual reports on the progress of designing and incorporating outcome evaluation instruments in their quality assurance program.

All recruitment and retention incentives available need to be utilized to counteract the critical shortage of VA health professional personnel. This issue is discussed in some depth in this Independent Budget document, especially emphasizing the enhancement of ongoing VA education and training programs. Three personnel--related legislative proposals also address this need.

The VA should be persuaded to step up the realignment of its health care facilities to better accommodate the long-term care impact of the aging veteran. This especially includes a more rapid conversion of excess hospital beds to nursing home units and targeted increases in non-institutional extended care programs.

The VSOs recommend that the VA identify at least one small secondary type care hospital, in geographic proximity to a tertiary care referral VAMC, for total conversion to a prototype multilayered extended care center complete with ancillary geriatric programs for full continuity of service and liaison with community long-term care facilities and programs.

The VA should be encouraged to be more flexible in the optional use of innovative programs to maintain a proper balance of modalities to meet the demands of a changing health care environment.

Funding should be provided for the expansion of Geriatric Research, Education and Clinical Centers (GRECCS) to the authorized number of 25 over the next three years. Correcting the time table slippage in acquisition of these units will come close to having a GRECC in every one of the VA's 27 medical districts.

The remarkable success of sharing agreements between VA and Military Medical Services warrants expansion wherever mutual interests are to be served.

To help correct the alarming shift of funds and deterioration of patient care in the DM&S Prosthetic and Sensory Aids Service, the entire PS&AS budget should be fenced and controlled through centralized allocation.

RECOMMENDATIONS FOR MEDICAL AND PROSTHETIC RESEARCH

We are recommending a research appropriation to restore the resource level depleted by recent budget erosions and provide a renewed vitality to pursue answers to some of the most pressing medical problems ever faced.

RECOMMENDATIONS FOR MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

The DM&S Central Office has never been so ill prepared to suffer any further budget absorption of uncontrollable expenditures. We submit that Medical Administration is already marginally staffed to manage the multiple crises stemming from under funding and under staffing throughout the VA health care system. The VSOs feel it is imperative that the MAMOE budget be restored to a valid current services level, with full funding of all unavoidable additional expenditures anticipated throughout the coming budget year. The only incremental request beyond a true FY 1990 current services level has to do with the need for increased funding of AIDS related education.

RECOMMENDATIONS FOR CONSTRUCTION PROGRAMS

An appropriation level of $275 million for minor construction reflecting the importance of updating and repairing VA facilities, primarily treatment facilities, the bulk of which were constructed in the decade of the 50's.

An appropriation level of $635 million for major construction, almost entirely devoted to medical treatment facilities, reflecting the VSOs urgent concerns for the unacceptable erosion of this vital element of the national infrastructure.

Prompt development of an adequate planning system which would permit the VA to project available construction dollars against a rationally devised national construction strategy which prioritizes requirements for construction and repair.

Within major construction, an appropriation of $6 million to begin to buy land for cemeteries that will have to be added to the National Cemetery System to meet what the VSOs see as a minimum acceptable level of available and accessible burial space.

Within major construction, $40 million for advance planning and design funds to keep projects moving forward efficiently.

Within major construction, $30 million for 4 new 120-bed VA nursing homes each year. Within minor construction, $40 million to be earmarked this year for conversion of existing VA hospital beds to nursing home beds, with a projected requirement to fund $20 million for this purpose annually through the year 2000.

LEGISLATIVE PROPOSALS

We are submitting, separately, legislative proposals on the following subjects:

Increase VA incentive bonus pay for physicians by a figure which corrects for inflation since the legislative enactment of 1979;

Provide entitlement to all Category A veteran patients for the full array of outpatient services;

Authorize and fund an associate degree education program for VA employees for training in various health care disciplines. Candidates should receive full VA salaries during a two-year academic schedule along with tuition, books and related fees. Two years of obligatory service should be required for each year of academic support;

Mandate that the VA establish a veterans' cemetery in every state;

Transfer of all veterans' benefits programs to the Department of Veterans Affairs, i.e., veterans' employment program transferred from DOL to DVA; and

Support re-introduction of S 2462, a bill by Senator Cranston which proposes funds to health professional schools affiliated with VA medical center to increase the number of students entering VA staff "shortage areas."

RECOMMENDATION FOR ESTABLISHING CONGRESSIONAL SUBCOMMITTEES

With the creation of the Department of Veterans Affairs, we recommend that the Appropriation and Budget Committees of the Congress create subcommittees for Veterans Affairs. This is important in terms of the new status of veterans programs and the budget impact of veterans programs which approximate $30 billion per year.

RECOMMENDATIONS FOR A REVISED BUDGET FORMULATION PROCESS

The VSOs recommend that Congress direct the VA to establish specific goals in its budget justification that represent the level of service to veterans and their families that are to be provided with the appropriations requested. The budget analysis supporting the appropriations requested should include the VA's assessment of how the resources provided will be used to meet stated goals.

RECOMMENDATION TO REVISE THE VETERANS ADMINISTRATION BUDGET FORMULATION METHOD

PREFACE

As a preface to this recommendation, some observations are in order concerning what the VSOs believe are prerequisites for responsible budget formulation. For any budget formulation methodology to be effective and responsible, it is necessary that all parties to the process approach their work with an attitude of mutual respect and cooperation, keeping in mind that the purpose of budget formulation is to provide funds for the resources necessary to efficiently implement and administer legislatively mandated programs for veterans and their families. In practice, this attitude is absent from the budget formulation process, making the process one with form but no substance. This situation must be corrected if the following recommendation is to have its intended impact. To restore an environment conducive to substantive and responsible budget formulation, the VSOs urge Congress to:

o Urge the elimination of all barriers to the flow of information between OMB and senior VA officials holding operational responsibility;

o Declaim OMB's practice of imposing upfront guidance based on preconceived budget limits. OMB staff would be much better informed if VA officials could start the budget cycle by submitting to OMB, free of censor enroute, their full assessments of needs and justification for resource requests to meet those needs;

o Urge the reopening of ongoing informal dialogue between these parties, which has been largely lost since 1980;

o Dissuade OMB from further purely arbitrary, budget cuts with no reference given to any understanding of impact; and

o Cause to be preserved and included in the final President's budget the cons as well as the pros of all controversial budget actions.

RECOMMENDATION

The VSOs recommend that Congress direct the VA to establish specific goals in its budget justification that represent the level of services to veterans and their families that are expected to be provided with the appropriations requested. For example, in the GOE account, specific goals would be set with respect to the timeliness of claims adjudication actions and the accuracy of those actions.

The budget analysis supporting the appropriations requested should include the VA's assessment of how the resources provided (and any existing or planned management initiatives) will be used to meet the stated goals.

This methodology for budget formulation adopts sound business and management principles and techniques and, in a sense, merely requires the VA to explain exactly what it means by such statements in the budget justification as, "The requested FTEE level for 1989 will provide continued good service to our veterans." In enacting appropriations, Congress must know what the VA means by "good service" and how the VA expects the requested appropriations to enable it to continue to provide that "good service."

A definition of "good service" expressed in terms of measurable and understandable workload data must be provided by the VA in its budget justification. This is not difficult and should not be burdensome. To illustrate the methodology, the goal of the timely processing of compensation claims can be used as an example.

Example

Goal: To complete disposition of original compensation claims in a timely manner.

Target with resources requested for FY 1990: To complete action on 35 percent of all original compensation claims within 90 days and 75 percent within 6 months. Currently, 27.9 percent of original compensation claims are completed within 90 days and 70.4 percent within 6 months.

Analysis: Major backlogs of original compensation claims have developed because:

o CP&E has experienced large staff losses and heavy personnel turnover in recent years without a corresponding decrease in workload;

o Experienced personnel have devoted as much as one-third of their time to training new employees; and

o It has been difficult to maintain a smooth work flow because of large backlogs in all areas of case processing. At times, this requires diverting personnel from their assigned work to ease more critical backlogs in other areas.

To meet the goal for FY 1990, the backlog must be reduced to a more manageable level. This will require additional FTEEs. For FY 1990, we are requesting a staffing level of ______ FTEEs (an increase of ______) at a cost of $______. Once trained and fully productive, it is estimated that these additional FTEEs will complete ______ end products (EPs). Based on our projected new case receipts during FY 1990, with the additional FTEEs, the October 1990 pending of original compensation cases will be reduced to ______ cases.

Other initiatives already underway will increase productivity of both experienced and new staff personnel. Centralized training of adjudication personnel has been established. It is anticipated that this will result in a savings of ______ FTEEs because (1) fewer experienced personnel will be needed to conduct training, and (2) new employees will become fully trained and productive four weeks earlier than under the earlier training modality.

Also during FY 1989, several manual processes were automated. The full benefit of these initiatives will be apparent throughout FY 1990. The savings from these initiatives are estimated to be the equivalent of ______ FTEEs.

(Any other initiatives that would also contribute to increased productivity during FY 1990 would be described.)

Our FTEE request for FY 1990 in conjunction with productivity gains will enable CP&E to process cases in a more timely manner. With these resources, we also can expect progressive improvements in succeeding years.

The above example illustrates that our recommended methodology will:

o Clarify instead of obfuscate the political and fiscal issues that Congress must address in the appropriations process;

o Ensure that the Executive and Legislative Branches are reading from the same book throughout the budget formulation process;

o Interject more accountability into the budget process by permitting an accurate assessment of whether the VA has understated or overstated veterans' needs and the resources needed to meet them or whether Congress has enacted insufficient appropriations to meet unmet needs and, if so, why;

o Make the VA's budget justification more understandable to the VSOs and Congress;

o Enable Congress to more easily fulfill its oversight function on a continuing basis because the VA's performance can be tracked by objective indicators, e.g., the extent to which the VA is meeting its goal on timeliness;

o Encourage, if not require, the VA to conduct meaningful and realistic planning to accomplish its mission;

o Establish a goal-directed and service-delivery orientation throughout the VA workforce; and

o Enable OMB to ask the hard questions of VA. management within the proper context, i.e., how can adequate service be provided to veterans in the most cost-effective way and what does the VA plan to do to achieve that goal.

The FY 1990 Independent Budget presentation that follows is an example of how the recommended methodology can be formalized and used effectively by VA managers and employees.

GENERAL OPERATING EXPENSES AND MISCELLANEOUS

GENERAL OPERATING EXPENSES - BENEFITS PROGRAMS ADMINISTRATION

PRINCIPLES AND GUIDELINES FOR BUDGET FORMULATION

The recommendations for Benefits Administration are based upon the following:

1. Staff for benefits programs must be adequate to assist veterans who seek information by providing timely, responsive, and accurate information; to process claims for benefits in a timely fashion; and to assure the speedy disposition of appeals.

2. Training and staffing in benefits programs offices must be adequate to ensure high-quality work, including the application of uniform national standards.

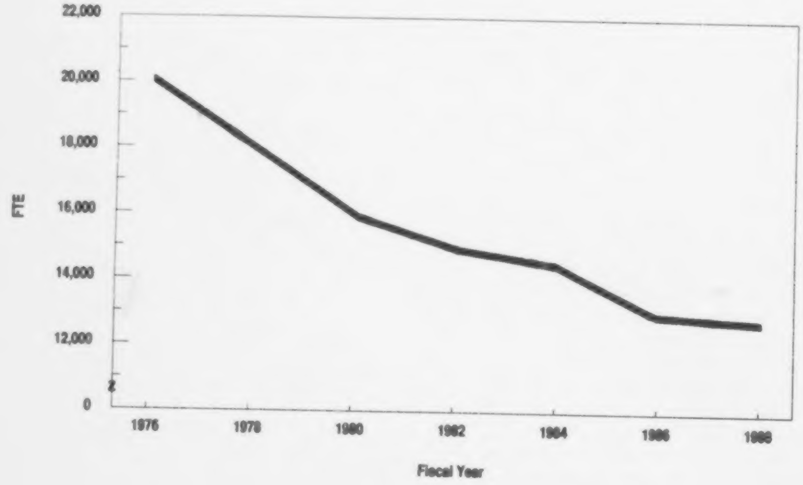
GENERAL OPERATING EXPENSES

THE CHALLENGE

The FY 1989 Independent Budget recommendations for GOE were based on a detailed analysis of the major problems with this account: draconian reductions in FTEE over an extended period that has resulted in unacceptable service to veterans in terms of the quality and timeliness of adjudication actions (see Chart 1); the demoralization of the overworked Department of Veterans Benefits adjudication workforce; and a corresponding inertia reflected by a lack of management movement on critical initiatives, such as automated data processing (ADP) modernization, quality control, and training.

The FY 1989 Independent Budget recommended appropriation for this account was $821.2 million, or 2 percent over the amount needed to maintain current services (i.e., the funds necessary to maintain services at the FY 1987 level). Given the fact that appropriations for GOE are used to administer all non-medical VA benefits programs and the documentation regarding the deterioration in essential services to veterans, the VSOs believed that the Independent Budget appropriations request was modest. Indeed, because of the depth of the problems, instant solutions, budgetary or otherwise, were not considered possible, especially within a climate of fiscal austerity.

Chart 1
DVB Employment
FY 1976 to 1988



Realistically, the immediate challenge was to reverse what had been a long-term trend of arbitrary budget cuts in the GOE account that were made at the expense of service to veterans and their dependents. The VSOs, however, also hoped that the initial Independent Budget on VA Benefits Programs, even if not adopted completely, would also create a new environment within the budget process. In this regard, the VSOs believe it is imperative to have an environment where an accurate and realistic assessment of what is needed to deliver service to veterans would again become the baseline for budget formulation.

That this perspective had been absent in the OMB-dominated budget process was confirmed by the Administration's budget request for FY 1989. That request, for $771.3 million in budget authority for GOE, was $3.5 million lower than the estimate for 1988 and $40.1 million lower than the FY 1988 budget request. Incredibly, the FTEE request for FY 1989 was 562 lower than the 1988 estimate. For the Department of Veterans Benefits (DVB), the largest component of GOE, the budget request was for 492 fewer FTEEs. Moreover, personnel resources are further eroded because of shortfalls caused by payraises and other personnel cost add-ons. Absorption of these costs by the VA results in correspondingly fewer FTEEs, or in furloughs, or other measures that have the same negative effect on service to veterans.

The challenge articulated in the Independent Budget for FY 1989 for the GOE account, "to assure that benefits to veterans are made available to them in a timely, effective and cost-efficient manner," has not been met. Significant progress, however, has been made. For example, both the House and Senate Committees on Veterans Affairs adopted some recommendations made in the VSOs' Independent Budget. Consistent with the data presented in the FY 1989 Independent Budget, these committees not only recognized the need for staffing above current service levels, but made recommendations on specific numbers of FTEEs for particular activities within the GOE account. Moreover, the committees made recommendations for appropriations to fund badly needed initiatives such as ADP modernization and training of adjudication personnel, recommendations that were consistent with the Independent Budget proposals.

The response of the Veterans Affairs Committees was particularly gratifying to the VSOs because these committees have great expertise not only in the substance of VA programs but in the manner in which they are intended to be administered. The VSOs believe that the merit of the recommendations made in the FY 1989 Independent Budget have been accepted by the congressional committees most knowledgeable in the area of veterans' issues.

This momentum, however, was not sustained through the critical point of the appropriations process. The staff cuts recommended in the Administration's budget request were summarily rejected; however, in place of this recommendation, the Appropriations Committees opted only for a maintenance of current services with respect to FTEEs. The VSOs will demonstrate that with this level of funding, the level of service to veterans will deteriorate further during FY 1989, from already clearly inadequate levels. This, then, is the challenge for the FY 1990 Independent Budget: to document that the real needs of veterans are not being met and to have cost-effective solutions to meet those needs reflected in actual appropriations. Put another way, the challenge for the VSOs is to finally cast the budget-making process in the light of reality and, in so doing, ensure that the political issue of adequately delivering duly-enacted programs to veterans and their families is not avoided, but addressed in the only meaningful way—appropriations to meet those needs.

OUR STRATEGY

Our strategy is once again to offer credible and economical, yet effective solutions to problems identified in GOE. The major problems identified in last year's Independent Budget not only remain, but have worsened. Our recommendations for improved staffing, improved ADP systems, a training program for DVB staff, and the installation of a quality control system will of necessity be reiterated because appropriations to fund these needed initiatives were not provided in the enacted appropriation bill for FY 1989. Updated information documenting the further deterioration of service to veterans will be provided to demonstrate that it is imperative that funding for these recommendations be provided by Congress, not only beginning with FY 1990, but with a supplemental appropriation for FY 1989 (see Table 3).

TABLE 3
GENERAL OPERATING EXPENSES
1990 Independent Budget Summary of Recommended Increases

	FY 1989 Supplemental Appropriation Recommendations			FY 1990 Recommendations	
	FTEE	FY 1989 (6 month's) $(000)	Annualized for FY 1990 $(000)	FTEE	$(000)
DEPARTMENT OF VETERANS BENEFITS					
Veterans Services:					
Workload Backlog	130	$2,076	$2,076	-0-	-0-
Compensation, Pension and Education:					
Workload Backlog	215	3,390	3,390	250	7,883
Establish Centralized Training Unit	15	236	236	-0-	-0-
Loan Guaranty:					
Workload Backlog	140	2,006	2,006	-0-	-0-
Vocational Rehab and Counseling:					
Workload Backlog	61	1,202	1,202	-0-	-0-
ADP Systems Management:					
Improved ADP Systems	-0-	15,000	-0-	-0-	25,100
TOTAL - DVB	561	$23,910	$8,910	250	$32,983
DEPARTMENT OF MEMORIAL AFFAIRS	-0-	-0-	-0-	35	3,200
TOTAL - GOE	561	$23,910	$8,910	285	$36,183

TABLE 4
GENERAL OPERATING EXPENSES
(dollars in thousands)

GOE ACCOUNTS	1988 Approp.	1989 Approp.	1989 IB Current Services*	1990 IB Current Services	1990 IB Recomm. Approp.
Veterans Benefits	520,230	515,860	556,300	590,200	623,200
Memorial Affairs	47,100	45,620	47,220	49,420	52,620
General Administration	207,500	212,840	217,940	228,340	228,340
TOTAL APPROPRIATION	774,830	774,320	821,460	867,960	904,160

*Funds necessary to maintain services at the FY 1988 level

TABLE 5
EMPLOYMENT -
GENERAL OPERATING EXPENSES

GOE ACCOUNTS	1988 Appropriation	1989 Appropriation	1989 IB Recommended	1990 IB Recommended
Veterans Benefits Administration				
Executive Direction	488	464	464	464
Veterans Services	2,146	2,061	2,276	2,276
Compensation, Pension,and Ed	3,637	3,600	3,867	4,117
Loan Guaranty	2,100	2,078	2,240	2,240
Insurance	438	458	439	439
Voc. Rehab & Counseling	653	650	714	714
ADP Systems Manage.	404	419	419	419
Support Services	3,006	2,920	2,920	2,699
TOTAL DVB	12,872	12,650	13,339	13,368
National Cemetery System	1,202	1,203	1,203	1,238
General Administration	4,014	3,919	3,919	3,459

DEPARTMENT OF VETERANS BENEFITS (DVB)

The Department of Veterans Benefits (DVB) administers most of the VA's non-medical benefits and services to veterans and their dependents. It does so through a chain of 58 regional offices (some are medical/regional office centers) as well as nationwide toll-free telephone lines. The benefits it administers include compensation for service connected disabilities; pensions for low-income, aged, or disabled veterans; vocational rehabilitation; education and training support; home loan guaranties; and life insurance. Our budget and staffing recommendations for DVB are summarized in Tables 4 and 5 on pages 31 and 32.

DVB OVERVIEW

What must be stressed is that despite FY 1989 appropriations to fund DVB activities at essentially a current-service level, the problems in DVB will worsen with that level of funding. During FY 1987 and FY 1988, for example, the timeliness of adjudication actions on compensation and pension claims decreased from already unacceptable levels. Because of antiquated ADP systems and the corresponding necessity of maintaining labor-intensive manual work processes, and inadequate staffing levels, important mail goes unread and unanswered. In many VAROs, high graded employees are required to perform clerical functions. Organized and consistent program training for DVB employees to improve quality and timeliness cannot be accomplished because of lack of funds and resources. This despite the fact that there was a 25 percent turnover of employees in FY 1986, in large part because of "early out" retirements, a rate which, in itself, demonstrates the demoralization of the DVB work force. The most telling evidence of the devastated state of DVB is a skyrocketing backlog of unworked cases.

These are just some illustrations of what has happened with a current service level of appropriations. Because of the budget cycle, this is the level of funding that will be provided to administer and deliver VA non-medical programs for the period October 1, 1988 through September 30, 1989. With this level of funding, there is no hope of improvement for the immediate future and, therefore, a supplemental appropriation for FY 1989 is clearly essential. This situation, which is directly caused by years of inadequate funding, is most disturbing to the VSOs and must be equally so to DVB employees, not to mention the neglected veteran beneficiaries and claimants. Within this depressing environment, the VSOs once again will propose cost-effective measures, both for FY 1989 and FY 1990 that are designed to reverse the accelerating downward momentum of deteriorating service to veterans and to begin the process of gradually restoring the level of service achieved by DVB before the past decade of arbitrary budget cuts. In short, the events of the past year demonstrate that the largest burden under which DVB labors is the practice of using depressed current service levels as the baseline for formulating the budget for the following fiscal year. The practice incorporates all the abuses of earlier budgets and guarantees that the aggregate total of progressively worsened service to veterans will carry forward with each succeeding year.

In the FY 1989 Independent Budget, the VSOs attempted to expose the fallacy of this type of budget formulation by establishing a realistic baseline for DVB FTEEs needs. Our recommendation for CP&E FTEEs illustrated what we contend is the only realistic approach to take. An exhaustive analysis of CP&E workload and FTEE data from FY 1978 through FY 1986 was conducted. During that period, an FTEE reduction of 18.7 percent would have been justified based solely on the volume of work, after accounting for any productivity gains. A reduction of 37.6 percent actually occurred. This was accompanied by major decreases in the timeliness of adjudication. For example, in 1979, the VA's own standards called for action on 50 percent of original compensation claims to be completed within two months and for 75 percent to be completed within three months. In FY 1987, only 16 percent were completed in two months, and only 31 percent were completed in three months. The facile response was for the VA to greatly lower its standards for timeliness, but even these much diluted standards have not been and are not now being met.

The VSOs contend that DVB's ability to process cases in a timely manner must be the single most important consideration in budget formulation. The rationale for our position was presented in the FY 1989 Independent Budget:

> Clearly, what has been ignored in the current budget process is the inescapable interrelationship among timeliness, the volume of work, and the number of employees available to accomplish the work. If the volume of work decreases, staff cuts are appropriate, but only to the extent that timeliness of service is maintained. The constant in the three-part equation of timeliness, volume, and number of employees must be timeliness, unless a conscious decision is made to allow the timeliness of work to deteriorate. Such a decision potentially affects millions of people, and should not be made for arbitrary budgetary reasons. Rather, because it has major public policy implications, it should be made only after careful congressional consideration. Moreover, there must be recognizable accountability for any such decision. Obviously, this has not been the process that has been operative over the past decade, although the OMB-driven process has led to unacceptable timeliness performance.

Estimating that one-third less of an FTEE reduction would have maintained reasonably timely action, the VSOs incorporated the timeliness factor in its methodology in determining what a realistic baseline would be for formulating the FY 1989 budget. The results: FY 1986 CP&E FTEEs should have been 4,230 instead of the actual 3,583, or 647 more employees (see Appendix A). Compared with this baseline of 4,230, which the VSOs contend realistically reflects what was necessary to deliver adequate service, the FY 1989 Independent Budget recommendation was for a net decrease of 393 CP&E FTEEs based on an anticipated workload reduction. This is the proper perspective from which the FY 1989 Independent Budget recommendation for 3,852 FTEEs for CP&E should have been viewed. Perhaps the message was not clear. The budget process must recognize that current DVB service levels are not acceptable. They are valid for budget formulation only insofar as they are the starting point for determining the extent of the additional appropriations necessary to restore adequate service levels.

DVB also must labor under the myth that productivity gains can automatically be anticipated, that nothing new must be done to achieve them. This, too, was a major theme of the FY 1989 Independent Budget. The fact is just the opposite: The status quo causes productivity regression. The continued use of old techniques, outdated equipment, and outmoded work processes creates bottlenecks and unwarranted processing delays. This, in turn, creates additional work: responding to inquiries on delayed cases, shifting resources to respond to backlogs in some areas, thus causing backlogs in the components from which the resources have been shifted, etc. Inevitably, quality suffers; more cases are processed incorrectly and must be worked again. Only so many holes can be plugged before the dike collapses.

Productivity gains are achieved by new learning and new tools to improve the timeliness and quality of work processes, especially in labor-intensive areas. Meaningful and lasting productivity gains also require an environment of innovative management and a work force motivated by the expectation that cost-effective suggestions, by those closest to the work, for improving service are not only encouraged, but supported with the resources needed to implement them.

In the view of the VSOs, these essential conditions for productivity gains do not currently exist within DVB. The major reasons for this are the long-term effects of OMB-directed budget cuts. This can be quantified in terms of the lack of adequate, tangible resources such as FTEEs, but the VSOs must again stress the very real demoralizing effect the cuts had on DVB employees. The best solution is a commitment through specific appropriations to provide badly needed ADP modernization and program training for DVB employees. Even a modest appropriation in these areas will have an incremental effect if, as anticipated, DVB managers and employees become convinced that the budget process recognizes their real needs and responds to them, at least to some extent. These additional resources are an investment that will provide real returns in terms of increased productivity and, just as importantly, create an atmosphere in which the full potential of the DVB work force can be utilized.

The problems of DVB are varied and complex and there is no single or simple solution. The VSOs do not have sufficient ready access to the data necessary to determine precisely what is needed in every DVB component to restore and maintain adequate service delivery to veterans. That is VA management's job. DVB management must be given the support to develop a comprehensive and cohesive planning process for the sole purpose of restoring and maintaining adequate service to veterans. The plan must persuasively articulate resource needs to achieve specific service-delivery goals by specific target dates. The VSOs are convinced that this methodology will not only make the VA's budget formulation more realistic but will also enable DVB managers and employees to focus their efforts on their primary task—delivering good service to veterans.

The Independent Budget fills the void created by a lack of needs-based budget formulation by the VA. In the future, the VSOs hope the VA will adopt the methodology used in the Independent Budget. When this occurs, the role of the VSOs will change. Instead of developing budget recommendations from scratch, the VSOs will be in a position to assess a definitive plan for service delivery developed by the VA. The VSOs will then be able to provide constructive comments and suggestions to the VA and Congress on resource needs relating to each aspect of the plan.

The FY 1990 Independent Budget, however, must again include a zero-based type of analysis. In some instances, the specificity of our recommendations will be limited because obviously the VSOs are not equipped to examine the DVB's entire operation in depth. Nor do the VSOs desire to do so. We do, however, have a wealth of data, all of which shows that additional resources and management initiatives are necessary to put DVB back on the course of restoring and maintaining adequate service to veterans.

Our recommendations for dealing with the problems associated with DVB activities remain essentially the same as last year because the situation has not improved; the basic problems have actually worsened due to a lack of appropriations to meet real needs. Those plans are:

o Staff increases in areas of DVB where shortages are most critical;

o Enhancement of DVB's existing automated systems while the VA proceeds with its integrated systems modernization plan; and

o Improved training for DVB employees, again concentrating on DVB functional areas in which training limitations have led to the most severe problems.

The need for these initiatives was critical last year. The funding requested for them in the FY 1989 Independent Budget would now be in use. However, because appropriations enacted in FY 1989 provided no additional funding beyond the inadequate current service levels for DVB FTEEs, ADP modernization, or program training for adjudication personnel, the predictable result has been further deterioration in the quality and timeliness of service to veterans. This downward spiraling cycle must end.

SPECIFIC RECOMMENDATIONS

We turn now from an overview of DVB to our specific recommendations for its individual components.

EXECUTIVE DIRECTION

For FY 1990 operate at the 464-FTEEs FY 1989 budget level.

The Executive Direction component of DVB consists of the offices and staffs of the Chief Benefits Director (CBD, the head of DVB) and three major units of DVB (field operations, program management, and ADP systems management), each under a Deputy Chief Benefits Director.

Service Delivery Goals: To implement a budget formulation process based on management planning that:

o Identifies veterans' unmet needs;

o Establishes goals that define "good service" to meet veterans' needs;

o Proposes cost-effective means to restore and maintain good service to veterans;

o Establishes target dates for achieving specified goals;

o Persuasively justifies the need for resources necessary to achieve goals by the established target dates; and

o Provides the basis for assessing the performance of all DVB managers and employees.

Analysis

Unquestionably, DVB is in a state of crisis. As will be described below, all components within DVB face major problems yet DVB management has not received the tools or support it needs from the top in order to propose, much less implement, either short-term or long-range solutions to these problems.

Notwithstanding the lack of desperately needed appropriations, many things can be done and are within the control of the VA's top management. For example, it would be reassuring to the VSOs if the VA made a more forceful case for increased appropriations necessary to adequately serve their constituency—veterans and their families. This should not be difficult in the face of the evidence of mountainous backlogs of claims and rapidly decreasing timeliness of completed actions. There is, however, no indication that the VA is publicly fulfilling its responsibility to be the advocate for providing the resources necessary to serve the needs of veterans.

We realize that OMB is largely responsible for the VA's apparent inability to make a forceful, independent presentation to Congress of its budget needs; nonetheless, it is difficult to imagine how the Administrator can preside over the ruinous situation in which the VA finds itself and defend a budget that requests a reduction of 492 FTEEs in DVB for FY 1989. In the face of such an attitude, innovation and initiative in lower levels of management invariably are stifled just when they are needed most. Moreover, there is a resistance to change even when resources to implement improvements are offered, as the following example illustrates.

At a recent hearing before the House Veterans Affairs Subcommittee on Oversight and Investigations, VA officials testified regarding systems modernization. They reiterated that target delivery dates for new equipment that would allow real-time benefits processing for the proposed integrated system could be estimated before 1990. In the meantime, the VA has established a 13-point interim agenda designed to enhance department computer systems during the transition to the integrated system. These short-term improvement projects involve individual programs where the VA plans to increase system functionality or automate a manual process. To date, however, the VA has completed only 2 of the 13 points in the plan. Moreover, interim improvements apparently are not a high priority as no appropriation for systems enhancements was requested for FY 1989. In explaining why suggested additional money or staff was not being requested to speed the process along, a VA official pointed to the Social Security

Administration (SSA) as an example of where added spending expanded a modernization project instead of condensing its completion schedule. The official stated that SSA's Computer Modernization Program is now 6 years off schedule and millions off budget.

The VSOs believe that this criticism of SSA to justify the VA's inactivity is inappropriate for a number of reasons. First, SSA's administrative costs for delivering benefit payments, expressed as a fraction of total benefit payments, is 1.1 percent. The VA's administrative costs for delivery of benefit programs under the GOE account is 4.8 percent of total benefit payments. SSA's administrative costs include funding for computer modernization. The VSOs hope that the VA will be able to match SSA's performances, but this cannot be done without greatly improved systems capability.

SSA's systems modernization has hardly been perfect; however, given the enormity and complexity of the project and the rapidly advancing technology, any modernization entails elements of risk. The degree of risk diminishes considerably, however, when compared to the potential for improved service and long-term cost savings as well as the alternative of inaction, which guarantees an increasingly inefficient, costly, and labor-intensive operation.

Moreover, despite many problems, SSA's systems modernization is already the cause of some major achievements. A short time ago, SSA's capacity to record the earnings of millions of workers was woefully inadequate and the entire operation was on the brink of disaster. Systems modernization has turned the situation around. Also, all 22,000 terminals necessary to implement SSA's Field Office Systems Enhancement (FOSE) project will have been installed and all field personnel trained by the end of 1988. Now a claimant for retirement benefits can have his or her first check in a matter of days. Contrast this with the veteran who applies for pension benefits.

Finally, now that a major portion of the SSA's plan has been funded and implemented, the percentage of administrative costs versus benefit payments will certainly decrease further while, at the same time, there is every indication that there will be improved service to the public and productivity gains. One can only speculate on what the amount of SSA's administrative costs would now be and what the state of service to the public would be if SSA had proceeded with systems modernization in the same way and at the same pace as has the VA.

The kind of budget formulation recommended by the VSOs should put an end to the VA's status quo attitude by requiring VA management to articulate specific goals for service delivery and propose the means to achieve them. The VSOs remain confident that DVB management is equal to this task. We also believe that meeting clearly stated goals that are related directly to service delivery should be the basis for all merit pay and employee performance plans.

In this era of budget austerity, veterans and their families have no chance of receiving adequate service unless VA management responds to their needs by aggressively developing innovative solutions to long-standing problems. In the sections that follow, the VSOs offer several suggestions as to how top management can attack the massive problems that permeate DVB within the context of a responsible budget formulation process.

VETERANS SERVICES

Increase staffing by 130 FTEEs over the FY 1988 actual for a total of 2,276 with a FY 1989 supplemental appropriation. Maintain staffing at 2,276 for FY 1990. FY 1989 (6 months) cost is $2,076,000. The annualized cost of this recommendation for FY 1990 is an additional $2,076,000.

The Veterans Services component of DVB provides information, advice, and assistance regarding veterans' benefits to veterans, their dependents, and their survivors. This information and advice is provided in person—primarily at regional offices—over nationwide toll-free telephone lines and by correspondence. The Veterans Services program also conducts outreach activities aimed at disadvantaged, elderly, homeless and other special groups of veterans. Veterans Services personnel also oversee payment of VA benefits to legally incompetent veterans and have program approval and compliance responsibilities for educational and training institutions in the VA's education benefit programs.

Service Delivery Goal: Reduce the abandoned call rates to 5 percent by the end of FY 1989 and to 2 percent by the end of FY 1990.

Analysis: In the FY 1989 Independent Budget, the VSOs expressed their dismay regarding the 11-percent abandoned call rate during FY 1986 and the fact that the VA was cutting staff levels in Veterans Services even though hundreds of thousands of veterans' inquiries and requests for information were going unanswered. The VSOs recommended a return to the FY staffing level of 2,276 FTEEs or an increase of 148. FY 1989 appropriations maintained the current service level of 2,128 FTEEs.

Nonetheless, the Senate Appropriations Committee expressed some of the frustrations that are felt by the VSOs with respect to the VA's delivery of service to veterans. In the report accompanying H.R. 4800 (the appropriation bill) it was stated that:

> The Committee is concerned with the VA's response to the Committee's request in last year's report for a study of a toll-free hotline that would offer the Nation's veterans benefits information and provide medical personnel with patient histories in the event of an emergency. The study was submitted over 5 months late and failed to address the concerns which the Committee directed the VA to examine.
>
> The Committee directs the VA to conduct a new study that should include the following: an inventory of existing toll-free services, the number of veterans using each service annually, and remaining services, along with the number of veterans they serve annually, which do not have toll-free services; the error rate, by account of information provided by existing toll-free services; the feasibility, including the costs and personnel needed, of consolidating the various toll-free services into one number so as to submit a reprogramming or supplemental appropriations request in fiscal year 1989 to implement such a hotline. The Committee directs this study to be concluded by no later than February 15, 1989.

Unquestionably, an improved telecommunications system, in conjunction with enhanced ADP systems and employee training, would not only restore adequate service in terms of responding to veterans' inquiries, but also permit much needed outreach programs. This is the cost-effective administrative and budgetary answer. Immediate and accurate answers to all veterans' inquiries could be provided and, at the same time, the volume of written inquiries, followups, and replies would be substantially reduced. This would also streamline claims processing by having necessary documentation available sooner and by permitting adjudication personnel to devote full-time to adjudicating cases rather than performing other tasks. The potential benefits of such a coordinated system are unlimited.

Veterans are in a Catch-22 situation when it comes to the Veterans Services activity. The more abandoned calls there are, the fewer telephone interviews must be done. If a veteran's call is unanswered, there is less work for the VA. The VA reports a decline in the abandoned call rate from 11 percent to 9 percent; however, given the level of service, this is more likely due to many veterans simply giving up attempts to contact the VA rather than any real service improvement. For example, the VA's 1988 estimate for the number of telephone interviews is 183,566 fewer than the 1987 actual and the 1989 estimate is 363,461 fewer than the 1987 actual. In any event, the VA standard that posits a 10-percent abandoned call rate as "acceptable" performance is the epitome of lowered expectations. The VSOs observe that any management team (private or public sector) that thinks it is acceptable to not respond to 10 percent of its potential customers and to make thousands of others wait interminable periods for a response is not doing its job. We also observe that it is difficult to imagine how much worse the situation would be were it not for the efforts of the VSOs in supplying information regarding VA benefits to veterans and in extracting claims-related information for veterans from the VA.

The VSOs have no realistic expectation that the equipment and training necessary for the Veterans Services component to do their job properly will be provided, much less be operational in FY 1990. We therefore have no alternative but to repeat our recommendation that Veterans Services staffing should be restored to the FY 1986 level of 2,276 FTEEs. Funding for the additional 130 FTEEs should be provided in a FY 1989 supplemental appropriation. The additional FTEEs should be allocated for Veterans Benefits Counselor positions.

The VSOs are convinced that an improved telecommunication system is a prerequisite for significantly improving service and productivity. When such a system is operational, movement toward achieving the service delivery goal will be accelerated. At that time, it may be appropriate to reevaluate staffing levels. Until then, however, additional FTEEs clearly are needed to restore adequate service.

The VSOs urge the VA to complete the study directed by Congress accurately and on time. We also suggest that Congress direct the VA to consider the Social Security Administration's (SSA) experience in implementing a nationwide 800 number phone service for all general incoming calls. The VSOs believe that SSA's system has considerable merit and that its experience is relevant to the needs of the VA.

Without the results of the study directed by Congress, the VSOs are not in a position to recommend an appropriation for FY 1990 other than to fund at the current-service level as supplemented by the proposed FY 1989 appropriation. We do, however, expect to see active planning for obtaining the equipment and training that appear to be necessary to achieve the goal of a 2-percent abandoned call rate by the end of FY 1990. Moreover, the VSOs observe that the ultimate goal should be not only a zero percent abandoned call rate, but an increasing use of telephone service by veterans as well as the implementation of outreach programs.

COMPENSATION, PENSION AND EDUCATION

Increase staffing over the FY 1988 actual by 215 FTEEs for a total of 3,852 and provide nationally standardized training with 15 additional FTEEs with a FY 1989 supplemental appropriation. FY 1989 (6 months) cost of these recommendations is $3,626,000.

The annualized cost of these recommendations for FY 1990 is an additional $3,626,000.

For FY 1990, increase CP&E staffing by 250 FTEEs (over the FY 1989 supplemental appropriation) at a cost of $7,883,000. For FY 1990, the appropriation should support a staff of 4,117 (including training personnel).

The Compensation, Pension and Education (CP&E) component of DVB processes veterans' claims for compensation pension, and education benefits and administers payments of these benefits. Annual payments to veterans under these benefit programs total approximately $16 billion.

Service Delivery Goals

Reduce the pending CP&E workload to the 10/87 level of approximately 170,000 by the end of FY 1990; meet or exceed all "acceptable" timeliness standards for the disposition of end products (EPs) by the close of FY 1990.

Analysis—FY 1989

Processing CP&E claims and delivering benefit payments to which veterans are entitled by law, in an accurate and timely manner, is the primary mission of CP&E. Inadequate appropriations for essential staffing resources over an extended period (10 years) have made it impossible for CP&E to accomplish its mission.

The FY 1989 Independent Budget recommended a staffing level of 3,852 FTEEs for CP&E, which was considered the minimum number necessary to begin the process of restoring service to an adequate level. This recommendation was based on an analytical methodology that:

- o Examined historical CP&E workload data using the VA's own work measurement system;
- o Analyzed historical staffing levels using the work measurement system as a tool to determine the adequacy of the staff to process the volume of work;
- o Applied a factor that accounts for the essential ingredient of timely disposition of claims.

This methodology remains valid and the full rationale supporting it is contained in Appendix A, "Measuring the Need for Compensation, Pension and Education Staff in the Department of Veterans Benefits."

The VA reports a FY 1988 actual of 3,637 FTEEs and our recommended increase uses this figure as the baseline. The VSOs, however, observe that as of August 31, 1988, the CP&E full-time employment total was 3,569. This equates to the actual current service level. The VSOs are convinced that if CP&E is forced to function with these resources, the results will be disastrous in terms of service to veterans. We therefore strongly urge that the recommended supplemental appropriation for FY 1989 for 215 additional FTEEs be provided. This would put the CP&E staffing level at 3,852 FTEEs, the number recommended in the FY 1989 Independent Budget. Our reasons for making this recommendation follow.

All indications are that CP&E is in a crisis situation. There is an alarmingly increasing backlog of cases; adjudication continues to be more untimely; and there is one example after another of rapidly deteriorating service caused by severe resource shortages. All three of these factors will be discussed so that there can be no doubt regarding the current catastrophic situation.

Backlogs

o Compensation and Pension (C&P)

There are three broad categories of cases: original compensation and pension claims; claims for supplemental adjudication; and ancillary actions and claims. In October 1987, the pending workload in these categories of cases was: 43,571 original C&P; 107,387 supplemental adjudication (adj./suppl.); and 16,729 ancillary action and claims. The pending as of August 31, 1988 was 118,640, 204,282, and 40,013 respectively. The VA's projection for the pending in October 1989 is 208,487 original C&P; 354,564 adj./suppl.; and 120,400 ancillary claims. These totals are depicted in Table 6.

With current resources, the pending backlog will quadruple over a two-year period. This is the reality of inadequate resources to do the job. There are more claims than can be handled by current staff. It is inevitable that there will be an accelerating decrease in timeliness and quality in equal proportion to the increasing backlog. The VSOs believe that if Congress recognizes the situation it will act. A supplemental FY 1989 appropriation for additional FTEEs to process C&P claims is desperately needed. There should be no mistake, however: This recommended supplemental appropriation is not the entire answer; additional funds for training and ADP are also needed for FY 1989.

Education

As of August 31, 1988, the total education pending was 28,418 compared to an October 1987 actual of zero. The VA's projection in the FY 1989 budget was that in October 1988, the education pending would be zero. A zero pending is also projected by the VA for October 1989.

Timeliness

The FY 1989 Independent Budget emphasized the poor state of timely service to veterans. This is illustrated by data that showed overall decreases in the timeliness of completed actions to clearly unacceptable levels. The situation is exacerbated by the lowered expectations of the VA, which are reflected in diminished standards for timeliness that are still not being met.

The unacceptable performance in timeliness was shown by comparing FY 1987 data and standards with earlier years when funding was considerably higher. During the past year, the unacceptable performance has worsened. The VA has acknowledged this. The VA's Chief Benefits Director stated in testimony before Congress on February 18,

TABLE 6
C&P PENDING (BACKLOG)

	C&P Orig.	Adj./Suppl.	Ancillary	Total
October 1987	43,571	107,387	16,729	167,687
Current	118,640	204,282	40,013	362,935
October 1989 (est.)	208,487	354,564	120,400	683,451

1988 that CP&E was meeting an acceptable level of timeliness in only 5 of the 28 timeliness standards; he related this to staffing shortages. Two years ago, the "acceptable," albeit much diluted, standards were being met in 11 categories. The slippage in timeliness was most apparent in the area of original claims. Two years ago, the standards were being met in 12 of 16 categories. As of January 31, 1988, they were being met in only 3 of 16 areas. This has serious impact on service to veterans.

For example, in FY 1987, 31 percent of initial disability claims were completed within 90 days and 75 percent were completed within 6 months. The cumulative 12-month data for the period ending August 31, 1988, shows that only 27.9 percent of those claims were completed within 90 days and only 70.4 were completed within 6 months. With the staggering increase in backlogged cases that has occurred with current resources, the timeliness data for FY 1989 can only be disastrous. Unless resources are increased now, the situation will only get worse. Of even greater concern is the accelerating downward momentum of poor service. Next year, timeliness will decrease at least in proportion to the increase in pending cases.

Cold workload statistics have the greatest impact on those who use them as tools on a daily basis, i.e., administrators and managers. The shocking reality they convey should be apparent to them; others, however, may not be aware of their full force. Once an entrenched negative trend is established, it feeds on itself, causing disruptions that spread and multiply. Adequate service no longer is the goal because it is impossible to achieve; attempting to deal with the disruptions and breakdowns consumes all the time and effort of managers and employees. The VSOs conducted a state-by-state survey, the results of which graphically illustrate this effect in the real world. The overall results of the survey and the fact sheets concerning their states were transmitted to members of Congress in August 1988. The survey included activities in VA Medical Centers (VAMCs) and VA Regional Offices (VAROs). The entire survey is recommended reading for all members of Congress so that they can get a national perspective on the reality of what inadequate appropriations mean to VA employees and to veterans and their families.

With respect to the VAROs, the survey documents a litany of problems, any one of which would be a major concern. Taken together, these problems are the reflection of a chaotic and rapidly unraveling work environment where adequate service to veterans is a hopeless expectation. Nationwide, there are huge backlogs, inadequate staffing, large turnovers in personnel, lengthy delays in claims processing, hearing and examination scheduling, typing and responding to correspondence. Training is virtually non-existent and, of necessity, there is the inefficient and costly use of higher-grade employees to perform clerical tasks because there are too few clerical employees to perform the essential non-adjudicative functions that begin and keep the process moving.

Recommended Actions - FY 1989

The first step must be to stop the continuing trend of deteriorating service. This can be done by the addition of FTEEs. Other steps, however, must also be taken. Labor-intensive manual work processes must be automated to the extent possible and an antiquated ADP system must be modernized. In addition, the need for centralized and standardized training must be recognized, funded, and implemented.

In the FY 1989 Independent Budget, the VSOs identified these obvious needs and proposed solutions to them within the budget process. Moreover, it was shown that it was cost-effective to do so. For example, it is difficult to understand how the local, ad hoc training of new employees, which requires one-third of the time of experienced personnel, can conceivably be a preferred alternative to more centralized, intensive training. With centralized training, normal operations would be disrupted less, new employees would become fully productive sooner, and the training would be more authoritative, consistent and accurate. With only a modest appropriation specifically earmarked for training, the initial cost more than likely would be offset by savings gained from the above-cited advantages during the same fiscal year; moreover, continued savings would result from a more productive and knowledgeable work force. The VSOs recommend a supplemental appropriation for FY 1989 of $236,500 to support a training staff of 15 FTEEs.

The VSOs are becoming increasingly frustrated with the inactivity on ADP modernization. No appropriations were requested by the VA for ADP modernization in the budget submission for FY 1989. In view of the disarray in CP&E operations described above and the improvement that ADP modernization could provide, this lack of movement is puzzling at best. It is almost as if the VA must be dragged into the modern age. The Senate Veterans Affairs Committee is aware of this problem and recommended an appropriation of $15 million for FY 1989 for ADP modernization. The VSOs strongly endorse this recommendation and believe that the recommended amount should be provided in a supplemental appropriation for FY 1989 in addition to the $25 million additional for FY 1990. (See discussion under ADP System Management on page 45.)

The VSOs do, however, observe that more than money is needed. VA management must display more initiative to modernize its operations. Action must be taken to get systems on-line soon. It is essential that VA-wide ADP policies be established to end the piecemeal, damage-control approach to automation. This need not be an all-or-nothing approach; particular work processes can be automated gradually after pilots have been successfully tested. Integration with DM&S systems and systems elsewhere in the government that contain information CP&E needs is the ultimate goal, but much can and should be done to improve operations through enhanced ADP while working toward that goal. This is essential if meaningful productivity gains are to occur. Moreover, without real improvements in this area, productivity will regress (see DVB Overview on page 32.)

In the view of the VSOs, these recommendations for FY 1989 supplemental appropriations are necessary to attempt to control damage that has already been done. Veterans cannot and should not be asked to wait yet another year before they can expect a reversal in the trend of deteriorating service.

RECOMMENDED ACTIONS–FY 1990

The baseline from which our recommendations for FY 1990 are being made is the supplemental appropriation for FY 1989 as proposed above. If supplemental appropriations are not provided for FY 1989, the recommendations discussed above would be incorporated with the FY 1990 Independent Budget. We are confident, however, that Congress will recognize the need for supplemental appropriations and act accordingly.

The biggest need, however, is to interject long-range planning into the budget process. That planning must be based on statistical assessments of current needs and specific goals to reduce backlogs and meet timeliness standards by specific target dates. CP&E's problems are so complex that they cannot be solved overnight even if a massive infusion of additional resources were provided immediately. The VSOs reluctantly must accept this reality because: (1) what would be needed to reduce backlogs to an acceptable level and to meet timeliness standards within a short period of time and what is needed to maintain an orderly and efficient work process for the long term are two different things, and (2) the number of additional FTEEs needed for a quick solution could not be efficiently assimilated immediately.

It is not unreasonable, however, to expect the pending workload (backlog) to be reduced to the October 1987 level and for all "acceptable" timeliness standards to be met or exceeded by the close of FY 1990. Veterans expect no less. Once these goals have been achieved, the resources and improved work processes needed for continued productivity gains will be in place. The VSOs want these goals to be the cornerstone of budget formulation for CP&E.

The VSOs believe that this is nothing more than recognizing reality instead of depending on the unrealistic budget projections inherent in the OMB-dominated process. For example, in formulating the FY 1989 budget request, the VA estimated that the C&P pending in October 1989 would total 259,156 cases, up substantially from the October 1987 actual of 167,687. The estimate for the FY 1990 budget, however, is that the C&P pending will be 683,451 in October 1989. The C&P pending as of August 31, 1988 totaled 362,935. The direct relationship between increasing backlogs and decreasing timeliness is inescapable. A brief analysis of the current situation will explain the depth of the backlog problem and the cold facts regarding the resources needed to begin to resolve it.

The rapidly increasing backlog of cases demonstrates that current resources are inadequate to process receipts. The backlog will therefore continue to grow. The requested supplemental appropriation for FY 1989 is expected to do no more than provide the resources to process the anticipated receipts during FY 1989. Those additional resources will not be able to have any significant impact on reducing the existing C&P backlog during the near term. Reducing the backlog to the October 1987 level will require considerably more FTEEs. Using the methodology introduced in the FY 1989 Independent Budget (see Appendix 1), it would take 438 fully trained FTEEs to reduce the projected October 1989 pending to the 10/87 level. The average base weight for C&P end products is .855. (The base weight reflects the number of employees needed to complete 1,000 end products in a year.) Applying this to an estimated October 1989 pending of 683,451 results in a weighted workload of 584,351. Thus, it would take 584 FTEEs to dispose of the entire backlog within one year. The VSOs believe that a pending approximating a three-month backlog of work by the close of FY 1990 is a realistic goal considering budget constraints, as well as difficulties that occur when "instant reform" programs are expected to work magic in a scenario of long-term serious problems. Until the backlog is reduced to this manageable level, veterans have no hope of a timely (i.e., within 90 days) disposition of their claims. The percentage of FTEEs needed to reduce the backlog to three months can be determined by dividing the number of projected pending by 4 (one-fourth of a year). Thus, 683,451 cases divided by 4 equals 170,862 (a number close to the October 1987 pending of 167,687). It follows that one-fourth fewer FTEEs (or 438) would be needed to reduce the C&P backlog to that level (584 x .75).

This illustrates the progressively worsening effect that previous staff cuts, combined with a maintenance of current service levels for FY 1989, has had on service to veterans. The crisis deepens and becomes unmanageable. To simply restore service to the inadequate FY 1987 level by October 1990 would require a major staff increase of 721 FTEEs (283 in FY 1989 plus 438 in FY 1990). The point is that when short-sighted budget submissions cause a crisis situation, the price that must be paid to correct the problem is ultimately much greater. Crash programs are costly and disruptive; they can be avoided by orderly and prudent planning that has as its centerpiece achieving and maintaining reasonable goals for the timely and correct processing of the workload. The time to begin that corrective planning is now.

The VSOs are willing to forego recommending an appropriation that would support the number of FTEEs needed to implement a crash program. We do, however, insist that there be a fundamental change in the direction and basis of budget formulation. The budget process must be a means to restore adequate service to veterans and their families. VA management should develop a plan that is directed toward reducing the C&P pending to the October 1987 level by October 1990 and having all "acceptable" timeliness standards met or exceeded by that date. Quarterly targets should be established and the goals and targets of the plan should be incorporated within Merit Pay and Performance Plans. The Congress should review VA's progress in accomplishing these goals within the normal oversight process so that if problems arise they can be addressed before the next budget cycle.

For FY 1990, the VSOs recommend budget authority for an additional 250 FTEEs over the FY 1989 supplemental recommendation of 283. New FTEEs can be hired gradually over the two-year period so they can be smoothly assimilated. Centralized, standardized training should be instituted so new employees can become fully productive as soon as possible. As they become trained, the new employees should be assigned to the VAROs with the lowest productivity and poorest timeliness. In conjunction with this activity, the VA must move on streamlining work processes by automating labor-intensive manual functions and improving ADP systems.

The VA should constantly assess resource needs in terms of meeting these goals. If reallocation of existing resources, productivity gains, and other initiatives are insufficient to meet established goals, a supplemental appropriation for FY 1990 should be requested.

VOCATIONAL REHABILITATION AND COUNSELING (VR&C)

Vocational Rehabilitation and Counseling (VR&C): Increase authorized staff by 61 over the FY 1988 actual for a total of 714 with a 1989 supplemental appropriation.

VR&C should fill and use authorized posi-

tions (see below). Maintain staffing at 714 for FY 1990. FY 1989 (6 months) cost is $1,202,000.

The annualized cost of this recommendation for FY 1990 is an additional $1,202,000.

VR&C provides assistance to veterans with service connected disabilities to help them achieve maximum independence in daily living, to become employable, and to obtain and maintain suitable employment. It also provides counseling services to veterans and members of the Armed Forces applying for educational and job training benefits and it operates career development centers. Its three main areas of activity are (1) rehabilitation evaluation and planning; (2) counseling and rehabilitation services; and (3) employment services.

These services are among the most important in the entire veterans' benefits area. VR&C carries out the nation's commitment to help veterans disabled in military service—those to whom we owe most—to function independently and to obtain suitable employment. These services, moreover, are beneficial to the nation because they help restore disabled veterans to the status of economically productive, taxpaying workers.

Service Delivery Goals: Reduce the Vocational Rehabilitation Specialist case load to an average of 125 and reduce the Consulting Psychologist case load to an average of 20 by the end of FY 1990. This should result in significant reductions in the time a veteran must wait for an initial interview and the time it takes for the veteran to be successfully employed.

Analysis

In the FY 1989 Independent Budget, the major and ongoing problems of VR&C were identified:

o On the average, veterans must wait 84 days from the time an initial application is received until they have an initial interview with a vocational rehabilitation specialist (VRS);

o An average workload of 182 cases for VA vocational rehabilitation specialists (VRSs) compared to a workload of 60 cases for comparable staff in the state/federal rehabilitation program;

o An increase from 155 days in FY 1984 to 232 days in FY 1986 as the average time from: (1) the completion of veterans rehabilitation program and their readiness to seek employment until (2) they have been employed for 90 days, which is the point at which rehabilitation is considered to have been successful;

o An average load of 25 cases for each consulting psychologist (CP) compared to an optimum case load of 20;

o Inadequate service to veterans as documented by General Accounting Office (GAO) and Inspector General (IG) studies; and

o An urgent need for training of VR&C staff in their specialized work.

However, there was one glimmer of good news: VR&C had finally received authorization to create a new position of employment specialist (ES). This would provide staff to perform a function for which the VA was given the responsibility seven years ago.

The FY 1989 Independent Budget request was for:

o 46 FTEEs for employment specialists, based on anticipated workload of 100 cases per ES;

o 69 additional VRS FTEEs to reduce the average VRS case load to 125; and

o 35 additional CP FTEEs to reduce the average case load to 20.

The current situation is:

o There are no employment specialists and the number of VRSs and CPs is still the same as last year, 168 and 170 respectively;

o The average VRS case load remains 182 and the average CP case load is now 26;

o The 1987 actual average of the number of days a veteran must wait for an initial interview was 90;

o The 1987 elapsed time from beginning of a veteran's rehabilitation through his employment for 90 days consumed an average of 255 days, compared to 232 in FY 1986 and 155 in FY 1984; and

- A 23 percent error rate exists on cases validated by Central Office staff, contradicting field station reports suggesting that a minimum level of quality was being sustained.

It is particularly noteworthy that the number of VRSs and CPs has not increased and that no ESs have been brought on board. The Administration Budget for FY 1988 recommended an overall VR&C FTEE level of 564 (a decrease of 16 from the current estimate). The usual statement that, "The requested FTEE level for 1988 will provide continued good service to our veterans," was included in the budget submission. Congress, however, provided budget authority for 661 FTEEs. Despite this fact and notwithstanding the separate and independent corroboration by GAO and the IG that service to veterans was clearly inadequate, the staffing level of the critical positions of VRS and CP remains the same; there is not a single ES on the job.

The reason for this is that VR&C is just one of many components within DVB. The additional VR&C FTEEs provided by FY 1988 appropriations were all allocated to the field. However, field resources and FTEEs are spread so thinly that there is a pressing need for additional personnel for virtually every activity, e.g., C&P, Loan Guaranty, VR&C, etc. There are simply too many holes to plug and station managers allocate available resources where they believe the need is greatest. In the real world, then, FTEE budget allocations for discrete activities can be artificial, especially when all components are in a crisis situation.

Based on current and anticipated workloads, VR&C must have a total of 244 (76 additional) VRSs and 205 (35 additional) CPs. There is also a need for 40 ESs. It is estimated that filling these ES positions would reduce the total number of VRSs needed to a total of 212. These FTEEs are desperately needed for FY 1989 and should be provided in a supplemental appropriation. With this level of staffing, significant improvement in the quality and timeliness of service should occur. The VSOs note, however, that the current error rate demonstrates that training is desperately needed and that suitable training programs are available through contract with the Department of Labor.

For budget purposes, the VSOs recommend VR&C staffing of 714 FTEEs. However, to ensure that those FTEEs are devoted to VR&C work, other DVB components must be staffed consistent with recommendations discussed elsewhere in this Independent Budget.

LOAN GUARANTY

Increase staffing by 140 FTEEs over the FY 1988 actual for a total of 2,240 with a FY 1989 supplemental appropriation.

Maintain staffing at 2,240 for FY 1990. FY 1989 (6 months) cost is $2,006,000. The annualized cost of this recommendation for FY 1990 is an additional $2,006,000.

The Loan Guaranty program provides housing credit assistance to eligible veterans and military personnel through guarantees of loans made by private lenders and through direct loans to certain severely disabled veterans.

Service Delivery Goals: Improve the cure rate percentage of loans that are in default to the FY 1983 rate of 85 percent (from a FY 1987 level of 77 percent) by the close of FY 1990.

Analysis

The major program and administrative problem in Loan Guaranty is the same—the alarming increase in defaults. In this discussion, we are concerned with the GOE, i.e., administrative, implications of defaults. The more fundamental programmatic problems will be discussed in the Benefit Programs section.

The increase in defaults was due largely to factors beyond the control of the VA. The fact is, however, that this activity was and continues to be inadequately staffed to efficiently handle the default problem. This has been costly. Many defaults that could have been cured are not; due to inadequate staffing, veterans are not provided with meaningful financial information and counseling. This results in more foreclosed properties the VA must manage and maintain and major increases in both program and administrative costs.

The VSOs also believe that, if staffing had been adequate, counseling could have been provided that would have prevented some loans from going into default. The VSOs are convinced that the poor level of service now being provided to veterans whose loans are in default is directly caused by short-sighted (and costly) budget formulation that failed to provide resources that would have greatly alleviated, if not cured, the problem.

Congress has been actively involved with the Loan Guaranty program and has enacted legislation (P.L. 99-576 and P.L. 100-198) that addressed many of the problems with this account. The VSOs supported this legislation and are encouraged and impressed by Congress' knowledge and grasp of the problems and with the insightful solutions presented in the legislation. Aggressive congressional oversight to ensure that the legislation is implemented as intended is perhaps the most effective way to improve service to veterans. There must also be congressional support for appropriations to provide the FTEEs needed to quickly and effectively implement this legislation and improve service.

In connection with the Administration's FY 1989 Budget, the Senate Veterans Affairs Committee recommended an additional 140 FTEEs for the Loan Guaranty activity. The VSOs concur with the committee's recommendation and supporting analysis. We recommend that an additional 140 FTEEs be provided through a supplemental appropriation for FY 1989.

We defer a recommendation for FY 1990, other than to maintain current services as supplemented by our recommendation for FY 1989. We do this because the VA has a number of initiatives that, if successful, will have a favorable impact on service to veterans and because we are optimistic about the chance that a long-term legislative solution will be enacted in 1989. In this regard, the VSOs strongly supported H.R. 5221, which was introduced in the 100th Congress and passed by the House. The bill includes a number of provisions we believe will begin to resolve the major problems of this program. The solutions are both cost-effective and long-term. Nonetheless, the quality of service to veterans that Congress expects, as demonstrated by enacted and proposed legislation, cannot be achieved without adequate staffing. The VSOs therefore caution that even if a bill similar to H.R. 5221 is enacted in FY 1989, it will not be the "big solution" unless budget authority is also provided for adequate staffing.

INSURANCE

The VSOs budget recommend a staffing level of 440 FTEEs for FY 1990.

ADP SYSTEMS MANAGEMENT

For FY 1990 operate at the 419 FTEEs FY 1989 level. Recommend a 1989 supplemental of $15,000,000 for enhancements to existing systems.

Provide $25 million for FY 1990 for ADP improvements.

The ADP Systems Management program is focused on the modernization of DVB's computer and telecommunications systems to provide better service to veterans and their dependents and survivors.

Service Delivery Goal: To develop and implement ADP and telecommunications improvements that will enable workload components to meet their assigned goals for FY 1989 and FY 1990.

Analysis

VA managers and employees must depend on this component for tools necessary to do their jobs effectively. Vastly improved systems capability is an absolute essential to restoring adequate service to veterans and producing an environment where real and ongoing productivity gains can be achieved. Given the abysmal state of service to veterans, the only alternative is to significantly increase staffing of workload components; if these staff were provided through appropriations, they could realistically be expected to do no more than man the pumps on the sinking ship of the VA while awaiting the more permanent solution of systems modernization.

Veterans, VA employees, the VSOs and Congress have already waited much too long. As we have shown above, the glacier-like movement toward systems modernization has had a devastating impact on service to veterans. The benefits of systems modernization are promised and staffing requests are contingent upon this promise. When the benefits do not occur, staffing is inadequate and service deteriorates. Veterans are held hostage in this gap between promise and reality; the ransom of deteriorating service increases each year.

The VSOs frankly resent this situation. In this age of extraordinary technological advancement, the incredibly slow pace of the VA's systems modernization is unconscionable. The time for action and results is long overdue; to delay is to regress. The VA is not immune to the consequences faced by all other businesses or organizations that refuse or are unable to quickly adapt new technology to outdated and inefficient work processes.

In the view of the VSOs, the ADP systems management activity has insulated itself from the real world, believing that their sole purpose is to work toward a global integrated system that may be online sometime in the future and that current problems will just have to wait for the arrival of the "big solution." The VA's attitude must change.

Just as workload components must assess veterans' needs, ADP management must assess what workload components need to deliver the service that will adequately address the needs of veterans. The purpose of ADP is to serve the workload components so that they may serve veterans.

The VSOs expect ADP systems management to develop plans to automate a number of work processes during FY 1989 and FY 1990. Their plans should incorporate close coordination with program components to assess their most pressing needs (and give them priority) and surveys of available equipment that can most efficiently meet those needs. Pilot studies using equipment from varied sources can and should be carried out. A corollary goal should be to streamline particular work processes with a view towards eliminating unnecessary or redundant manual functions and the unnecessary measurement of them. Target dates for implementation should be set and met. There must be incremental but ongoing improvements.

The VSOs also believe that ADP systems can and should include quality control features. For example, we strongly urge that systems modernization include features that will help guarantee that no veteran is deprived of due process. These could include checklists for DVB staff of procedural steps that should be taken, and automatic generation of text in notifications to veterans that set forth the veterans' rights in connection with the actions described in the notification.

The VSOs have recommended a supplemental appropriation for FY 1989 of $15 million to fund this activity. It cannot wait until FY 1990.

SUPPORT SERVICES

For FY 1990, provide a staffing level of 2,699 FTEEs as follows: 1,536 Administrative; 976 Finance; and 187 Personnel–a decrease of 307 FTEEs from the FY 1988 actual.

Service Delivery Goal: To improve substantive suport service to workload components.

Analsysis

The function of Support Services, like ADP Management, is to provide service to workload components. This activity is, of course, vitally important but its operation is almost exclusively internal to the VA. Because of this, the needs assessment necessary for budget formulation should be directed to the recipients of the service being provided, i.e., the workload components. The VSOs are not in a position to provide an informed needs assessment nor to make specific recommendations regarding the resources necesary to provide good service to workload components. We do, however, have some observations.

The primary concern of the VSOs in this account is the administrative support function. Because of the problems in the non-adjudicative functions of case processing that have been described above, the VSOs believe that, at a minimum, the number of FTEEs performing administrative tasks should be maintained at the FY 1988 actual level of 1,536. Certainly, the practice of having adjudication and managerial personnel perform clerical tasks canot be permitted to continue. The VSOs have no basis for objecting to the VA's proposed staffing levels for finance and personnel functions for FY 1990 (976 and 187 respectively).

The VSOs believe that a number of areas can be explored to improve service: enhanced ADP capability; streamlined work processes; flexible position descriptions that would enable employees to be trained to perform a number of work functions; and consolidation within the VA Regional Offices of work functions not directly related to claims processing, e.g., finance and personnel services.

DEPARTMENT OF MEMORIAL AFFAIRS (DMA)

Increase staffing by 35 FTEEs for FY 1990 to a 1,238 FTEEs level at a cost of $3.2 million.

The Department of Memorial Affairs (DMA), the second VA department funded by the General Operating Expenses (GOE) appropriation, carries out three main activities. It inters deceased veterans as well as members of the Armed Forces, their spouses, and certain dependents, in national cemeteries that have available grave space. Second, it provides headstones for these burials in national cemeteries and also for burials in private cemeteries. Third, it administers the program of grants to states for State Veterans Cemeteries.

Management of the National Cemetery System (NCS) as well as the procurement of headstones and gravemarkers is provided by a Central Office staff. Immediate supervision of the cemetery installations is accomplished through three National Cemetery Area Offices (Atlanta, Georgia; Philadelphia, Pennsylvania; and Denver, Colorado).

State Veterans' Cemeteries provide gravesites for veterans in those areas not served by national cemeteries, complement those cemeteries already established or planned for the National Cemetery System, and provide a vehicle whereby veterans who so desire and are eligible can be buried in close proximity to their home and loved ones.

A site selected for the location of a state cemetery is at the option of the state being served under methodology based on rules prescribed by the Veterans Administration.

The cemetery system is experiencing a steadily increasing workload in interments. VA projects an increase of approximately 56,500 interments for 1989. The number of graves that must be maintained continues to increase to a projected 1989 level of 1,775,000.

Service Delivery Goal: Maintain and improve the current level of cost-effective service.

Analysis

The VSOs are favorably impressed with the manner in which DMA is being managed. The FY 1989 budget justification for this account is a good example of responsible budget formulation. Current and projected workload trends affecting resource needs were discussed and the necessity of at least a slight increase in FTEEs, in addition to the continuation of the trend in increasing efficiency, was recognized and recommended to maintain adequate service in the face of a growing workload. The VSOs recommend an FY 1990 increase of 35 FTEEs over the current service level.

The FY 1989 budget justification included data on the location and status of national cemetery gravesites. These data reveal the following trends:

o With the dedication of the Central Florida Cemetery in May of 1988, the system now consists of 112 operating national cemeteries. The Arizona Veterans Memorial Cemetery will be transferred to the National Cemetery system and a new cemetery in northern California is scheduled to be opened in 1990;

o Through 1989, 51 cemeteries will be closed to new interments (cemeteries designated as closed may continue to inter eligible family members in already occupied and previously reserved gravesites);

o Nineteen states will have no national cemetery or have cemeteries that are closed to new interments; and

o From 1990 to 1994, an additional 10 cemeteries will be closed, and by the turn of the century, 8 more will close.

By the year 2000, 69 of the cemeteries existing in the system today will be closed to new gravesites. The need for a significant increase in available and accessible gravesites is obvious.

The VSOs believe that the goal of providing reasonably accessible gravesites for our nation's veteran population should be based on a policy of having at least one open national cemetery in each state. (Our legislative proposal for expansion of the national cemetery system is detailed in the chapters dealing with construction.) However, the

VSOs do encourage the efforts to expand the grants for State Veterans' Cemeteries. This is a feasible alternative in helping to alleviate the problem of accessible burial space and provides an option for veterans who reside in areas not currently served by a national cemetery.

GENERAL ADMINISTRATION

The third major function funded by the GOE appropriation, consists of the Office of the VA Administrator, other agency-level offices (except those involved with construction, procurement, and supply), with support offices (such as information systems and telecommunications), and the Board of Veterans Appeals (BVA).

For FY 1990, provide a staffing level of 3,459 FTEEs.

GRANTS FOR CONSTRUCTION OF STATE VETERANS CEMETERIES

This program provides for grants to states for the establishment, expansion, and improvement of State Veterans' *Cemeteries. At relatively little cost* to the federal government, it helps support a system of cemeteries reserved for veterans.

We recommend an appropriation of $6 million for FY 1990 consistent with Department of Memorial *Affairs' plan.*

BENEFITS PROGRAMS

BENEFITS PROGRAMS INTRODUCTION

The Veterans Administration administers the veterans benefits programs through funding provided by the General Operating Expenses appropriation. These benefits programs include over a dozen appropriations and revolving fund accounts. Most are self-financing or are funded by other government departments (principally by the Department of Defense) and require no VA appropriations. Only the five benefits accounts requiring VA appropriations are treated in this Independent Budget:

- o Compensation and Pension (C&P)
- o Readjustment Benefits (RB)
- o Veterans' Job Training (VJT)
- o Loan Guaranty Revolving Fund (LGRF)
- o Veterans Insurance and Indemnities (VI&I)

Benefit payments from these accounts result from determinations that veterans and their dependents meet requirements set by law. When those requirements are met, benefit payments are nondiscretionary, i.e., the government is obligated to pay them. Appropriations for these accounts are based on estimates of the number of individuals who will be entitled to benefit payments under these programs during the fiscal year. The VA is in the best position to make accurate estimates in this regard and the VSOs, therefore, concur with the appropriations requested for these accounts in the President's budget for FY 1990, realizing that if the estimates upon which they are based are low, a supplemental appropriation would be enacted.

TABLE 7
BENEFITS PROGRAMS APPROPRIATIONS
(dollars in thousands)

Benefits Accounts	1988 Appropriations	1989 Appropriations	1989 IB Current Services*	1990 IB Current Services*	1990 IB Recomm. Approp.
Compensation, pension, and burial benefits	14,832,400	15,460,600	15,460,600	15,685,600	15,685,600
Readjustment benefits	808,200	619,800	619,800	434,100	434,100
Veterans insurance and indemnities	14,300	13,470	13,470	13,900	13,900
Veterans' job training	0	0	60,000	0	0
Loan guaranty revolving fund	916,400	969,800	969,800	1,363,800	1,363,800
TOTAL BENEFITS PROGRAMS	16,571,300	17,063,670	17,123,670	17,497,400	17,497,400

COMPENSATION AND PENSIONS

The compensation and pension appropriation provides funds for disabled veterans compensation, their pensions, burial benefits, and some additional miscellaneous benefits. This account is not subject to budgetary control as such because benefit payments are fixed by law and made based on findings of legal entitlement. Thus, if veterans or their survivors are found entitled under the program, they will be paid benefits. This is so whether or not the budget request for FY 1990 is sufficient to cover payments to all entitled individuals. We do, however, have an observation to make. An entitlement is meaningless if the benefit cannot be delivered. Therefore, the link between staffing and servicing the benefits programs becomes crucial. This need for adequate staffing and servicing is fully described in the GOE section of the Independent Budget and is the cornerstone of the VA's ability to carry out the law that mandates the delivery of these entitlement benefits.

The VSOs certainly expect that sufficient funds will be appropriated so that there will not be a repeat of the situation where compensation payments to disabled veterans were delayed because funds in this account had been exhausted for FY 1988.

The primary strategy of the Independent Budget for this appropriation is to provide for equitable cost-of-living allowance (COLA) increases for veterans receiving disability compensation and pensions. Veterans are willing to bear their fair share of economies needed to reduce the deficit, and we will accept a reduced COLA if the Social Security COLA is similarly reduced and federal contracts are adjusted so that wage increases of contractor employees are similarly held down.

SPECIFIC RECOMMENDATIONS

Compensation: We recommend a cost-of-living (COLA) increase of 3.6 percent, effective December 1, 1989 at a cost of $318.1 million. Compensation is paid to veterans for disabilities incurred during active military service or aggravated during service. Death and Indemnity Compensation (DIC) is paid to survivors of servicepersons or veterans whose death occurred while on active duty or as a result of service connected disabilities. The rate payable depends on degree of disability (for living veterans), service rank (for survivors of veterans), and number of dependents for both veterans and survivors. In addition, a clothing allowance is provided for service-disabled veterans who use a prosthetic or orthopedic appliance that tends to wear out clothing.

A reversing trend in the declining compensation case load has developed during 1988. Compensation case loads appear to be increasing, as are higher average benefit payments for veterans and survivors. Some of the indicators are:

o Enactment of presumptive service connection legislation:

- for certain categories of prisoners-of-war.
- for certain radiation-related diseases.
- for certain veterans exposed to Agent Orange during the Vietnam-era.

o The discovery of approximately 10 million military hospital admission records that can be used in lieu of the military records destroyed during the 1973 fire at the National Personnel Records Center in St. Louis. The duplicate records cover the years 1942 to 1945 and 1950 to 1954, so they primarily affect veterans of World War II and the Korean Conflict who were previously denied compensation because of lack of evidence. Four months after the records were discovered, approximately 6,000 claims were attributed to this "second chance" discovery.

o The granting of veterans status to certain World War II merchant marines.

The schedule the VA uses for rating the degree of a veteran's disability and the service connectedness of the disability continues to be under siege. The VSOs are greatly concerned about any study or effort that may be an attempt to change the basic philosophic foundation of the rating schedule. The VSOs believe that the rating schedule is an excellent guide for the adjudication of service connected disabilities. Any basic change in the rating system is a public policy issue, not a matter of fine tuning, and should be implemented only through legislative action by the Congress. The VSOs therefore oppose any back-door approach, under whatever guise, to make fundamental changes in the VA's Schedule for Rating Disabilities without due congressional deliberation and explicit legislation.

The VSOs also wish to state again for the record that we are adamantly opposed to even the suggestion that any aspect of compensation be subject to any form of means test.

Pension: Pension benefits are paid to aged (65 or over) or totally and permanently disabled veterans of wartime service who have low income and to their needy survivors. (There is no disability requirement for survivors.) Amounts payable depend on income and number of dependents. Pensioners who have come on the rolls since January 1, 1979, receive "improved law" pensions that include an automatic annual COLA increase equal to the Social Security COLA, count almost all income in determining income for pension eligibility, and reduce pension amounts dollar-for-dollar for every dollar of income from other sources. Over half of pensioners and more than four of every five pension dollars are paid under the improved law program. Older pension programs have major income disregards, little or no reduction of pensions for income from other sources, and no automatic annual increases.

Pension is a needs-based program. Budget outlays are nondiscretionary, being based on individuals' meeting legal requirements, and benefit amounts are fixed by law.

The VSOs, however, wish to emphasize that pension recipients are particularly vulnerable and should therefore receive the full COLA increase mandated by current law for FY 1990. Clearly, there should be no tampering in terms of reduction or delay of the "automatic" COLA increase: it would be more than grossly insensitive—it would be catastrophic for these needy recipients.

Also, even though expenditures in this account are expected to remain static or decrease slightly, the budget process must anticipate increased expenditures in health care for the aging pension recipient population.

Burial Benefits and Miscellaneous Assistance: This portion of the compensation and pension appropriation includes burial benefits. These include burial and plot allowances, a flag to drape the casket of a deceased veteran, and furnishing a headstone or marker (or allowance therefore) for a veteran's grave.

The burial benefits are generally fixed-amount allowances. These modest tokens of the nation's last respect for those who served in the Armed Forces were cut in the "Balanced Budget and Emergency Deficit Control Act of 1985." The payment levels have been restored, and we counsel against similar cuts in the future.

Funding for mortgage protection life insurance for service-disabled veterans has been transferred to the Veterans Insurance and Indemnities appropriation. This proposal appears to be administratively sound and is supported by the Independent Budget.

The Administration's proposal to move funding of the Graveliner program from General Operating Expenses to this account seems feasible and, therefore, agreeable to the VSOs.

The VSOs continue to oppose those efforts to restrict the plot allowance ($150) to only those veterans in receipt of VA compensation, pensions, or to wartime veterans who are without resources to be buried. The plot allowance is a final token of their country's respect and should continue to be awarded to every veteran who served his country.

During the past year, the burial allowance for service connected deaths was increased from $1,100 to $1,500, effective April 1, 1988. The VSOs appreciate the efforts of Congress and the Administration that made this increase possible.

READJUSTMENT BENEFITS

Appropriations for these benefits fund three types of programs:

o Education and training (the "GI Bill") for Vietnam-era veterans and for dependents of veterans who died of a service connected disability or who have a permanent and total service connected disability. Expenses in this category are declining as Vietnam-era veterans exhaust their eligibility.

o Special assistance to service connected disabled veterans. This includes:

- A monthly subsistence payment plus tuition, books, etc., for disabled veterans enrolled in education or training as part of a vocational rehabilitation program. Most such beneficiaries are enrolled in college.

- Housing grants of up to $38,000 to aid certain permanently and totally disabled veterans in acquiring a specially adapted housing unit with the special fixtures and facilities necessitated by their disability.

- One-time grants of up to $5,500 for purchase of an automobile by certain severely disabled veterans and servicepersons. Additional funds for purchase and repair of special adaptive equipment for the automobile are also provided and are available on a recurring basis.

o Education and training under the "Montgomery GI Bill" for all-volunteer force veterans and certain Reservists. The Veterans Administration pays for basic benefits for veterans. Bonus-related supplemental benefitsfor veteransare paid for by the Defense Department. Spending in these programs is increasing as more veterans become eligible.

The VSOs have nothing but the highest praise for the Readjustment Benefits Program. It is the most successful entitlement program ever offered to a segment of the American people. These people are American veterans who educated and trained themselves with a little financial support from their government. Consequently, they have become taxpaying, productive, and successful citizens who have paid back the cost of their GI Bill Training many times over.

The numbers of Vietnam Era veterans, servicepersons, sons and daughters, spouses and widow(ers) eligible for education and training continues to decline as expected.

o The caseload of Vietnam-era veterans and servicepersons reaching their delimiting date or exhausting their entitlement will drop from 159,100 in 1989 to 90,000 in 1990, or a drop of 69,100.

o The caseload of spouses, widow(ers), sons, and daughters of veterans who died of service connected disability or veterans who are rated permanent and total will drop from 38,300 in 1989 to 34,000 in 1990, or a drop of 4,300.

o The number of trainees under the all volunteer "Montgomery GI Bill", composed of veterans, servicepersons, and Reservists, is expected to continue to increase.

o The first veterans with a full 3 years of eligibility under this program did not separate until after June 30, 1988. As more eligible persons separate from the military, the number of veteran trainees will continue to rise. 41,500 veterans and 185,300 Reservists are estimated for training in 1989, an increase to a level of 105,000 veterans and 214,000 Reservists in 1990.

Many of the enhancements made to the program to assist disabled veterans during the past year were Independent Budget proposals. For these and the other benefit improvements made by the Congress, the VSOs are grateful. The increase in the limitation for housing grants and automobile purchase grants for disabled veterans were particularly appreciated.

LOAN GUARANTY REVOLVING FUND

The Loan Guaranty Revolving Fund appropriation provides some of the funds required by the VA mortgage loan guaranty program. A fee equal to one percent of the loan amount together with income from the loan portfolio provides the remainder of the financing for the fund. The program's objective is to assist veterans in purchasing homes by substituting the federal government's guaranty of the loan for the security usually provided by a down payment (and by a shorter term of the loan). Thus, veterans are able to purchase homes without making a down payment and with lower monthly payments (because of the longer loan term). Veterans with a service connected disability of 10 percent or more are exempt from the one-percent fee.

This program is important for veterans and for the nation. By assisting more than 12 million veterans in purchasing homes, it has played a major role in fostering the American dream of home ownership, and has increased the tax base of virtually every community in the United States.

This account, perhaps more than any other, demonstrates the fallacy of the short-sighted OMB-dominated budget formulation process. Poorly conceived or simply mistaken "savings" represented by GOE staffing cuts quickly become apparent in the loan guaranty account when there is need for supplemental appropriations to keep the fund solvent.

Clearly, OMB has made a bad but manageable situation much worse because:

o Inadequate funding for GOE resulted in the VA's not having the resources necessary to focus effectively on the major problem area of the alarming increase in loan defaults (see discussion under GOE).

o Inadequate resources and the certain expectation that sufficient resources would not be provided greatly inhibited the planning for and implementation of management initiatives to improve the situation. As the crisis deepened, virtually every aspect of program management of Loan Guaranty was in need of improvement. For example:

- The issuance of "bad loans." Is this due to a need for the lender to bear more risk? Because the government will pay back the loan, there is little incentive for lenders to closely check the credit worthiness of the veteran. This does not benefit veterans and certainly has greatly increased program costs.

- Poor appraisal practices. More accurate appraisals would reduce the default rate.

- Poor maintenance of foreclosed homes. Obviously, this reduces the value and sale price of foreclosed properties.

- Poor marketing of properties. Improved marketing techniques are essential if full value and sale of foreclosed properties.

- Poor marketing of properties. Improved marketing techniques are essential if full value is to be reflected in the sale price of foreclosed properties.

If the VA had the assurance that recommendations for the additional resources needed to address and correct these problems would be supported, the current situation would be much improved. Program improvements undoubtedly will result in a major reduction in program costs.

The sad fact is that administrative initiatives and solutions have little, if any, chance of being implemented under the current budget formulation process. Congress at the least implicitly recognizes this and, of necessity, has become directly and deeply involved in analyzing the numerous program problems in order to propose legislative solutions. This demonstrates to us that Congress has lost faith in the VA's ability to implement effective administrative solutions or propose program changes that would return the fund to solvency without huge supplemental appropriations.

OMB's budget policies with respect to GOE have been devastating, but its insistence on accelerated loan sales has been at least as destructive to the solvency of the fund. The VSOs have no doubt that this policy was instituted solely for short-sighted budgetary reasons. In the FY 1989 IB, the VSOs were highly critical of this policy. This criticism need not be repeated because Congress has been just as critical of this policy that results in loan sales returning 56 cents on the dollar.

Despite these massive problems, the VSOs are confident about the future of the Loan Guaranty program. Congress has repeatedly stated its support for this highly successful and historically cost-effective program. Even more importantly, Congress has demonstrated the resolve to legislatively implement long-range solutions to ensure the solvency and effective administration of the program. As stated in the discussion under GOE, the VSOs are particularly impressed with the thoughtfully-crafted provisions of H.R. 5221, which passed the House during the Congress' last term. This legislation insightfully addresses virtually all of the problems discussed above. The VSO's strong support of this legislation is already a matter of public record and we urge and anticipate that Congress will reintroduce and enact this legislation as soon as possible.

Although the VSOs are optimistic that long-term solutions to the problems associated with the account will be found, undoubtedly an appropriation for FY 1990 will be necessary to maintain the solvency of the Loan Guaranty Fund.

Our recommended appropriation is $1,363,000.

The amount of this recommendation underscores the urgency for Congressional action to craft permanent long-term legislative soluations to the Fund's problems. The VSOs realize that it is difficult to predict accurately the appropriations that may be necessary to ensure the fund's integrity. If events make the President's recommended appropriation inadequate, the VSOs are confident that Congress will provide such appropriations as are necessary to maintain the fund's solvency.

We will close this discussion by observing that the Congress' involvement in the Loan Guaranty program is exactly the kind of direct activity in the budget formulation process that the VSOs recommend in the Introduction and throughout this Independent Budget. In other accounts, the problems caused by the OMB-dominated process, at least on the surface, are not as visible as in Loan Guaranty. The VSO submit that masking real problems is an inevitable consequence of the current process. The VSOs withhold judgment on whether this is intentional, but, in any event, we are confident that when these real problems in other accounts are brought to light responsibly, Congress will act just as decisively as it has in addressing the problems of the Loan Guaranty program.

VETERANS' JOB TRAINING

Recommend a $60,000,000 supplemental appropriation for FY 1989.

This program was established to relieve unemployment among Korean Conflict and Vietnam-era veterans who are unemployed for long periods of time. More specifically, the program provides reimbursement to employers who hire and train eligible veterans who have been unemployed 10 out of the 15 weeks preceding the date of application. The program pays one-half of the salary of each trainee up to $10,000. Since inception of the program:

o Nearly 62,000 unemployed veterans have been placed in jobs; and

o Applications have been processed from approximately 537,000 veterans and 80,000 employers.

SPECIFIC RECOMMENDATIONS

Legislation (P.L. 100-323) signed by the President May 20, 1988 extends the date that veterans must initially apply for this program to September 30, 1989. The new law also extends the date that veterans must begin training in an approved job program to March 31, 1990. $60 million was authorized for each of the fiscal years 1988 and 1989. Funds are authorized to be available through September 30, 1991.

The Administration failed to request any funding for FY 1988. The VSOs see this as an OMB-guided attempt to thwart the will of Congress. According to the Bureau of Labor Statistics, as of March 31, 1988, more than 623,000 veterans of the Korean Conflict and/or Vietnam-era were unemployed and nearly 26 percent of all workers whose jobs are displaced by foreign competition are veterans, although veterans make up only about 14 percent of the workforce.

This excellent program has provided nearly 62,000 veterans with the chance to gain the skills and on-the-job experience needed to break away from sustained unemployment and help them become productive, tax paying citizens. Thousands of eligible veterans are waiting to enter this program when funds for its operation become available. The VSOs recommend a 1989 supplemental appropriation of $60 million so that veterans can receive benefits that have been authorized to them by Congress.

The VSOs also recommend that the functions of the Department of Labor's Assistant Secretary for Veterans Employment and Training be transferred to the Department of Veterans Benefits. This has made administrative sense for a long time and the transfer is particularly appropriate now that the VA has cabinet-level status. This will not require an appropriation and should save money by having all veterans' employment functions consolidated under a single authority.

VETERANS INSURANCE AND INDEMNITIES

The Veterans Insurance and Indemnities appropriation consists of former appropriations for military and naval insurance (WWI), National Service Life Insurance (WWII), and Serviceman's Indemnities (Korean Conflict) and includes payments to service-disabled veterans insurance fund to supplement premiums and other receipts of the fund to allow veterans with service connected disabilities to obtain coverage at standard premium rates.

SPECIFIC RECOMMENDATIONS

The Independent Budget supports the proposal to fund the Veterans Mortgage Life Insurance program within this appropriation rather than through Burial Benefits and Miscellaneous Assistance. Mortgage protection insurance is provided for service connected disabled veterans who have received grants for specially adapted housing. The maximum amount of this insurance is $40,000.

MEDICAL PROGRAMS

MEDICAL PROGRAMS

PRINCIPLES AND GUIDELINES FOR BUDGET FORMULATION

Recommendations for medical programs are derived from the following principles and guidelines:

o VA patients should have available to them a sufficient quantity and balance of the various types and levels of medical care to promote maximum efficiency in the use of resources in the VA continuum of care.

o High-cost/high-technology programs should be placed so that equity of geographic access is ensured for all entitled veterans. These programs should be maintained only where workload volume standards can be met within a reasonable period of time. Sharing arrangements and joint ventures should be encouraged as a means of providing the benefits of such programs with quality, efficiency, and improved geographic access.

o High-cost equipment based technology, such as Magnetic Resonance Imaging (MRI) and other expensive diagnostic equipment, should be identified as new budget initiatives in a separate budget line item accompanied by a plan to diffuse the technology throughout the VA health care delivery system in the most expeditious manner.

o Equipment should be replaced based on schedules that recognize the rapidly changing character of medical technology and technological obsolescence must be acknowledged and adequately planned for as an essential basic element of state-of-the-art medical care.

o The inflation index for increments in the VA medical care budget should reflect increases in health care industry cost indices. (The hosptial market basket index and its components are available for this purpose.)

o Research focused primarily upon the diseases and disabilities of veterans along with the commitment to medical education complete the triad whereby the quality of veterans' health care is enhanced. We are dedicated to maintaining the caliber and integrity of the research program through consistent funding of not less than 2 percent of the medical care budget.

o In planning for the VA health care system, greater attention must be given to the interaction among the pluralistic systems of health care in the U.S. (e.g., impact upon the VA of reductions in Medicare and Medicaid funding, increases in co-payments, etc.)

o The VA has been a leader in vertically integrated health care delivery systems and this role should be enhanced by demonstrating increased commitment to a realignment of the VA health care system in response to neds of veterans. In particularl, the VA must swiftly convert excess hospital capacity to met nursing home care, other extended care and ambulatory care needs.

o Changes in the budget for the VA health care system should be based upon changes in the VA user population and on workload projections for the system that are based on current experience, past trends, and anticipated changes in the modalities of health care delivery.

o Resources needed for activating newly-constructed facilities should be accurately reflected in budget submissions and then provided in full as the facilities are activated.

o Assure that the Medical District Initiated Peer Review (MEDIPRO) teams have the capacity for effectively preventing the gaming of the DRG/RAM system and monitoring the quality of medical care in facilities under their surveillance. Encourage the VA utilization of outcome evaluation instruments as they are developed by such organizations as the Institute of Medicine (IOM) and the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).

o Newly enacted legislation for health care must be accompanied by adequate appropriations to implement the legislation--otherwise implementation should be at the discretion of the Agency.

o Within every VA medical facility, the integrity of the clinical team involved in direct patient care should be maintained, with VA management and staffing of the team. Only industrial-type services should be considered for contracting out, and then only if cost savings can be achieved.

MEDICAL CARE

The medical care appropriation provides for the delivery of VA health care in VA medical centers and other VA and non-VA health care facilities. This care includes inpatient hospital care, outpatient care at both hospitals and free standing clinics, institutional long-term care in nursing homes and domiciliaries, and several types of non-institutional long-term care. Also included in the medical care appropriation are the costs of the large-scale education and training programs conducted in VA health care facilities. In addition, the medical care appropriation pays for care of entitled veterans in non-VA facilities in the special circumstances under which the VA is authorized to pay for such care.

THE CHALLENGE

As described in the Budget in Brief, meeting the needs of aging veterans and maintaining access to quality care for all eligible veterans are the major challenges confronting the VA's medical care program.

MAINTAINING ACCESS TO QUALITY CARE

Because of the predictable growth in demand for services within the VA health care system accompanied by insufficient appropriation support, the system now faces serious problems in its ability to maintain quality care and to provide timely access to care to all entitled/eligible veterans. These problems have been created by budget-related developments in the health care industry, generally both in the private sector and in the VA. Veterans who are unable to meet increasing Medicare copayments are looking to the VA as a safety net. This is happening at the very time that VA underfunding and staffing shortages are seriously restricting access to and quality of services provided.

Access Barriers Impact Quality

The VA health care system has always been distinguished for offering patients a comprehensive, coordinated continuum of care. However, as entitlement and eligibility rules now stand under P.L. 100-272 and P.L. 100-322, many veterans in Category A[1], with clear entitlement to inpatient care, are not entitled to outpatient care except in the following circumstances: (1) for service connected disabilities, for veterans with 50 percent or more service connection, or those disabled by VA treatment or while in vocational rehabilitation, and (2) for certain categories to prepare for or obviate the need for inpatient care. Discussions with top management officials across the VA health care system indicate that the majority of VA medical centers are greatly reducing access to ambulatory care by restrictive use of the "obviate the need" clause. This is a dollar-driven decision made irrespective of a physician's professional judgment. Some hospital managers stated that because of inadequate resources, non-service connected (NSC) medically indigent veterans are provided ambulatory care only in acute emergencies. Basing a decision to provide or deny medical care on a variable and financially motivated interpretation of "obviating the need" leads to poor management of chronic illness--which requires regular periodic care. It is bad medicine--and often bad economics--to turn away veterans needing outpatient care on the grounds that their current condition is not sufficiently severe to require hospitalization. It invites acute, serious, and costly complications. It is also a contradiction of the current emphasis on non-institutional care and preventative medicine. Ironically, whereas the Category A medically indigent non-service connected veteran still has clear entitlement to all treatment provided on an inpatient basis, he has recently lost access to many procedures now shifted, under cost containment pressure, to an outpatient setting.

An even greater magnitude of denial of access to VA health care for non-service connected medically indigent veterans will occur soon should a

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[1] Category A consists of service-disabled veterans, ex-POWs veterans of WWI or earlier conflicts, veterans exposed to ionizing radiation and Agent Orange, recipients of VA pensions, veterans with Medicaid, and other low-income veterans. In total, Category A veterans number about half of the nation's 28 million veterans.

September 1988 announced CMD policy be made operational for lack of an early FY 1989 supplemental appropriation. This proposed policy is one of several provisions purported to address a serious shortfall in the FY 1989 medical care budget. Predicated on the rationale of equity in resource distribution, the volume of "discretionary" medical care in any DM&S district will be capped at a percentage of total workload to match that percent of discretionary care found to be the lowest in any VA Region. Once that assigned cap in discretionary medical care is reached in any given facility, excess funds will be withdrawn, presumably for redistribution to other accounts/medical centers.

Meanwhile, several VA medical facilities have publicly announced the discontinuance of all care for Category C as defined in P.L. 99-272, an option we feel is in marked variance with congressional intent.

Needy veterans turned away from the VA because of its tight restrictions on ambulatory care are likely to have no alternatives to the VA care they are denied other than Medicaid, and males under age 65 generally are not eligible for Medicaid no matter how poor they are. Thus, these veterans are likely to add to the uncompensated care burden that private providers are increasingly shunning, or fail entirely to obtain care when it is needed. (The Medicaid patient, incidentally, is provided ambulatory care regardless of the likelihood of hospitalization, an arrangement certainly more cost effective than inviting, through patient neglect, a crisis need for acute inpatient care.)

As identified through the telephone survey in the FY 1989 Independent Budget and substantiated by subsequent surveys of all VA hospitals by the House Veterans Affairs Committee and by surveys conducted by Veterans Service Organizations, wholesale restrictions on needed medical care for both entitled and eligible patients were evidenced throughout the VA system. Hearings by both Veterans Affairs Committees in Congress addressed this issue in depth on September 7 and 9, 1988, leading to charges that the VA had not been accurately identifying its true budgetary requirements over a period of years. It was also noted that the VA had been accommodating resource shortfalls by reprogramming funds from such other accounts as equipment, facility activations, and building maintenance and repair, and even resorting to closure of beds and denying or delaying patients' access to all or certain types of care. Aggravating the dollar short-falls is the increasingly serious staffing shortage of nurses and other allied health personnel in many VA hospitals.

Quality Erosion

The VSOs, as well as individuals in the VA health care system, are convinced that the system is losing its control over the quality of care it is delivering. Several indicators related to quality lead the VSOs to this conclusion. Some of the more general indicators that point to the erosion of quality of care in the VA system are: staff shortages, recruitment and retention problems, lack of funds to purchase such medical devices as artificial joints, unwarranted delays in the purchase of prosthetics and such medical equipment as wheelchairs, increasing amounts of nursing overtime, more restrictive use of "obviate the need" for NSC veterans seeking outpatient care, a burgeoning backlog of medical equipment that needs to be replaced, the use of discretionary funds to support non-discretionary recurring base requirements, and reduction of staff in such critical supporting areas as prosthetics and building maintenance. That these indicators are present across the system has been substantiated through evidence accumulated by the VSOs during the past year, much of which has been made available to the House and Senate Veterans Affairs Committees at their hearings on the VA "Shortfall" (September 7 and 9, 1988).

Quality of care is eroding as a result of the Administration's lack of concern for the health care budget of the VA, as well as a lack of understanding of the implications of underfunding this large and complex system year after year. The cumulative effect of underfunding and the concomitant need to support necessary and legislated personnel floors requires the Department of Medicine and Surgery to use funds from accounts other than those for personnel services to meet personnel funding requirements. Such action has created medical care delivery problems for the VA that, in the long run, will further threaten the quality of health care delivered in the VA system. For example, up-to-date equipment is necessary to provide state-of-the-art care; its lack in turn affects the VA's ability to recruit and retain health professionals.

Quality of care in the VA system is of primary concern to the VSOs, as is access to care for all Category A veterans. Our intent is to present a budget that accurately reflects the threats to access and quality and to propose cost-effective solutions to eliminate those threats. Quality in the VA system should not be perceived by veterans or their advocates as anything less than that which is perceived as the best the private sector medical care system. Access to the VA system should be guaranteed and effortless for entitled and eligible veterans. The VSOs and veterans expect the VA to provide the best in quality of care and, further, to demonstrate national leadership in such areas as spinal cord injury, other catastrophic disabilities, geriatric care, prosthetics and rehabilitation, and in long-term care.

A discussion of the national interest in quality assurance in medical care and the development of more effective evaluation instruments is provided on page 86.

MEETING PROGRAM AND WORKLOAD GOALS

The Independent Budget has been constructed on the premise that strategic direction should be the driving force behind operations; that is, the program and workload goals of the Department of Medicine and Surgery should be targeted to meet a general long-term goal. If the strategic direction is sound, then budget allocation to achieve the strategy should be the main objective of resource allocation. In the two previous budgets, the VSOs' strategy was explicitly stated along with a set of guiding principles. Although our goals and objectives for program and budget recommendations were not fully achieved, our review finds those previous recommendations to be sound: Had the recommended targets been achieved, then much of the current VA health care crisis might have been averted.

The VSOs have reassessed their position and are convinced that system change is necessary along the lines we continue to recommend. Selected system changes can take place without cost or with very minimal cost that would be in the best interest of serving veterans. For example, by simply activating a Geriatric Evaluation Unit in each medical center, a significant reduction of resource consumption could be achieved due to the rapidly increasing use of the system by older veterans and provide them a timely comprehensive assessment of medical care requirements--this could be accomplished without additional costs to the health care system.

The VSO targets are straightforward and relatively simple to achieve. Recommended program and workload targets should be realized even if resource shifts within the current environment are required to better meet the needs of veterans. A realistic set of goals and objectives for the next five years--together with the mechanism for achieving them--should be a requirement placed on the Department of Medicine and Surgery. Sound planning today will strengthen the VA health care system of tomorrow.

OBVIATING THE LOSS OF AFFILIATED TEACHING PROGRAMS

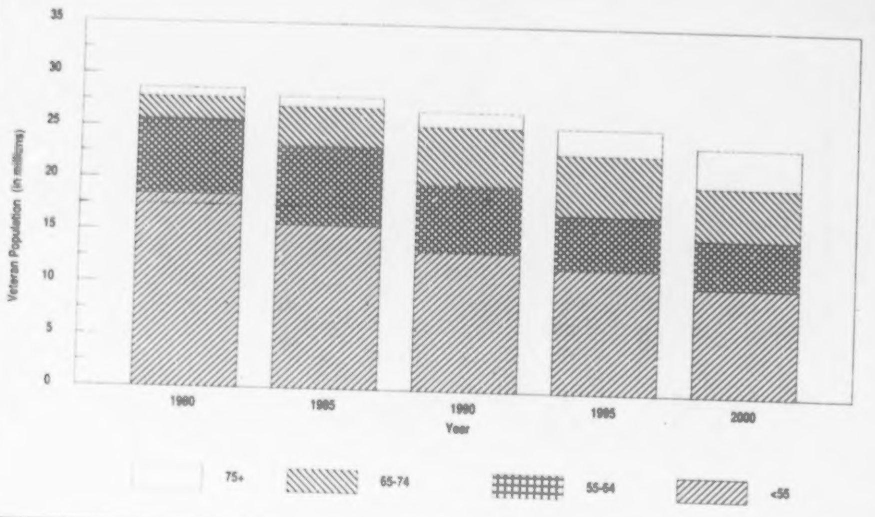
Ever since the inception in 1947 of affiliations between VA hospitals and the Nation's Medical School, programs for undergraduate and graduate medical education have been the chief source of professional staff recruitment and a major guarantor for quality medical care for veteran patients. These affiliated VA hospitals remain today the nation's single largest health manpower production resource. Over one--half of all physicians in practice have had some portion of their training in the VA health care system.

Current underfunding and short staffing of VA hospitals has caused a demonstrable compromise in the adequacy and quality of health care to a degree in which the Deans of the affiliated schools are registering their concern that continuation of these teaching programs may be in jeopardy. These concerns have been voiced in recent testimony before the Congressional Veterans Affairs Committees and made the subject of a December 1988 conference attended by members of the AMA Section on Medical Schools.

MEETING THE NEEDS OF AGING VETERANS

Beginning in the 1980s, most veterans of the World War II and Korean War eras (the largest groups of veterans) turn 65. The figures are dramatic, as Chart 2 shows. In 1980, there were 3.0 million veterans 65 or older; in 1990 there will be 7.2 million. By the mid-nineties, one third of all veterans will be over the age of 65, and by the year 2000, 9 million veterans will have reached this age group. As people age--particularly as they age

Chart 2
Veteran Population
1980-2000



beyond 65--they require progressively more health care, and their need for long-term care grows even more rapidly than their need for acute care. A few statistics on veterans' actual use of VA care underscore the point. As seen in Chart 3 on page 69, veterans aged 55-64 are the highest users of VA inpatient care among veterans under 65, using inpatient care at twice the rate of veterans under 25. However, veterans aged 65-74 still use VA hospital care 32 percent more, and those over 75 use this type of care 75 percent more than the 55-64 age group. Although this increase in use of VA inpatient hospital care is dramatic, it is small compared to the statistics for nursing home care. Chart 4 on page 69 shows nursing home use by men 85 and older is almost 30 times the use by men 55 to 64.

Meeting this rapidly growing and changing need of the aging veteran population is a very significant driving force behind our policy for the medical care appropriation.

VA PLANNING FOR THE HEALTH CARE SYSTEM

The VA health care planning system MEDIPP, was conceived and implemented as a mechanism to establish strategic and operational direction for the medical care system. Although the planning resources and processes have been in place for several years, the planning leadership has lacked the understanding, courage, and conviction necessary to force the process to respond responsibly. In the opinion of the VSOs, each change in the planning system has weakened it and with responsibility now residing in the Regions--the line offices that direct system performance--the program can produce but questionable benefit. This is exemplified by MEDIPP generally being perceived by the medical center directors and the medical districts as a mechanism through which program enhancement and increased resources can be accomplished rather than a mechanism

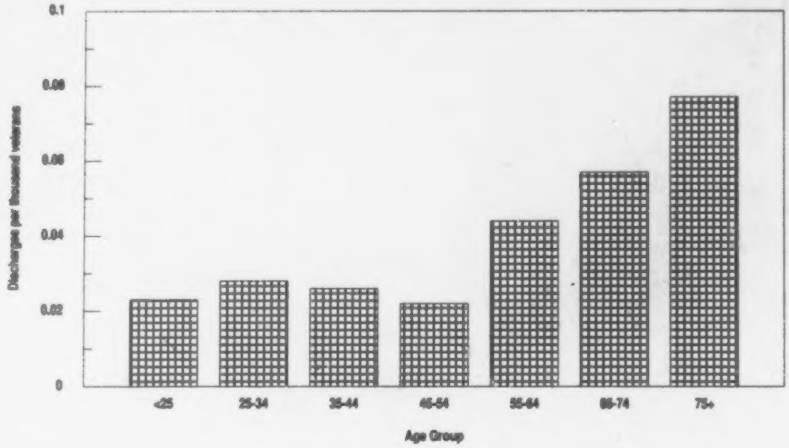


Chart 3
VA Hospital Discharge Rates
FY 1988

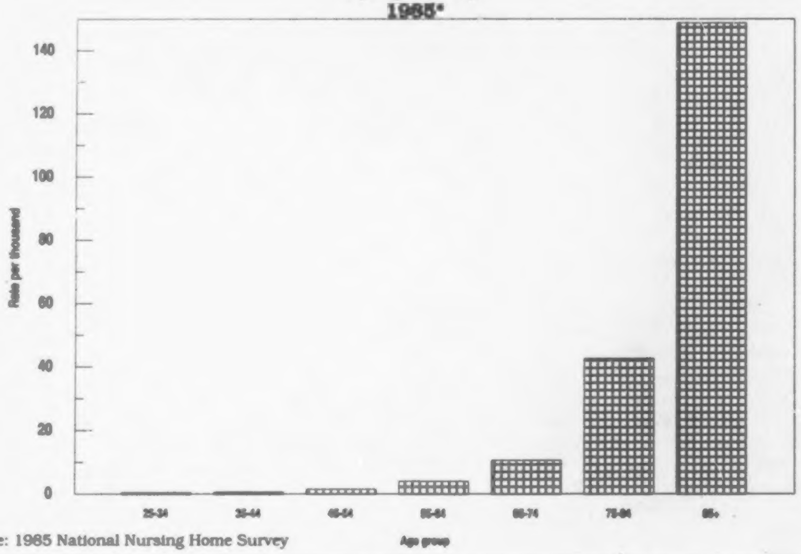


Chart 4
Nursing Home Use Rates
by Age Group
1985*

*Source: 1985 National Nursing Home Survey through which system change can be managed. If the planning program had been functioning as originally envisioned, MEDIPP would have been responding constructively to the continuing budget shortfalls and the system would not have found itself in a crisis situation in May 1989. The likely conclusion about MEDIPP now is predictable: The VA will pronounce that the system does not produce the desired result and it should therefore be abolished and planning left to the line officials. The VSOs strongly disagree with this position and suggest that DM&S step back and carefully assess MEDIPP and make the difficult decisions that will allow it to function in a manner supportive of the VA mission and top management decision making. Medical districts where MEDIPP functions effectively should be used as models for the entire DM&S. Suggestions for some general revisions of the VA health care planning program are presented on page 83.

VSO STRATEGY

REALLOCATE BENEFITS SAVINGS TO MEDICAL CARE

In part, the funds needed to accommodate the growing health care needs of the aging veteran population and address current quality and access problems could become partially available through the decreasing requirements of the aging of the veteran population on veterans' benefits programs. In much of the benefits area, unlike the medical area, the numbers of veterans receiving VA benefits will decline in future years. (Some specifics are pointed out in preceding sections on veterans' benefits programs.) As a result, in future years, the cost of the benefits will increase less rapidly than inflation. Any savings from benefits programs should be regarded as funds available to meet health care needs.

EXPAND NON-INSTITUTIONAL CARE PROGRAMS

Beyond this, our strategy to deal with unmet and growing needs in light of budget constraints continues to focus on rapid expansion of non-institutional health care programs. This focus holds in both acute and long-term settings. These non-institutional care programs not only cost less than institutional care but also provide veterans more independence and more opportunity for living with their families and in their communities.

The historical roots of the VA system, like its affiliated academic health care centers, are in institutional care--hospital inpatient care on the acute care side and nursing home care on the long-term care side. Like the private medical sector, the VA system has been moving to more use of non-institutional care--that is, to expanding both outpatient acute care and a variety of non-institutional long-term care modalities--and the results this last year have been gratifying in some respects. The shift to non-institutional care modalities must be continued; it is an important direction for the future.

MORE CLEARLY DEFINE VETERAN NEED

Another component of our strategy for addressing with unmet need is to undertake a series of data-gathering activities to identify more accurately the extent and character of the quality and access issues confronting veterans seeking and receiving health care. The House and Senate Veterans Affairs Committees have initiated action in this area by requesting the Government Accounting Office to "conduct a study to estimate the current and potential demand for VA outpatient care of veterans who have entitlement to VA hospital care." This must be supplemented with information to more accurately identify the unmet need of veterans for hospital, nursing home, and domiciliary care.

SPECIFIC RECOMMENDATIONS

Specific recommendations to implement this strategy follow. These recommendations are discussed in two general categories. First is the imperative to maintain current services--i.e., to continue to provide the same level of VA medical care services as was provided in FY 1988[2]. (Corrected for the deficiencies noted below). This followed is by specific program recommendations. Table 8 identifies these recommended programs and funding levels.

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[2] The assumption here is that the independent recommendations for a FY 1989 supplemental appropriation to meet the current services shortfall is acted upon its entirety.

CURRENT SERVICES

During the late spring and summer of 1988, the VA began to experience severe funding problems and anticipated equally severe funding problems in FY 1989. In the fall of 1988, the VA proposed making major adjustments to the medical care program to counter the effect of funding shortfalls that had accumulated in the medical care account over several years.

The Independent Budget--had anticipated these problems and argued for more accurate accounting of current services in order to establish a more realistic funding base. It was clear to the VSOs that additional funding was necessary to support the basic medical care program. Congress has begun to respond to the presentations in the past Independent Budgets and to support a more realistic current services level.

The medical care program is complex and is personnel-oriented: more than 60 percent of the medical care budget is directed to personnel costs. It follows that if the funds are not appropriated to support the congressionally mandated personnel floor of 194,140 FTEE then funds must be directed from other discretionary medical care accounts. This is the crux of the shortfall problem: The VA medical care program for a number of years has had to absorb the costs of pay raises and special pay increases, and increases in Federal Employees Health Benefits; it has also had to "pay" for excessive slippage factors in facility activations, the cost of inflation, and a forced reduction of personnel to match the dollar requirements for the decentralized hospital computer program.

In more recent years, attempts have ben made to force personnel productivity improvements upon the VA at a level of 1 percent per year. There have also been constant additions to existing entitlement to health care and expansions of the health care system (e.g., outpatient clinics) that were required to be implemented within the existing appropriation.

There is evidence that the VA equipment purchase backlog continues to grow and has become a serious liability to the Department. According to some tallies, this backlog exceeds one-half billion dollars and some estimates, by those in a position to know, place this backlog at more than one billion dollars. There also is evidence that, in some cases, the VA is using outmoded equipment that delays patient assessment and yields inaccurate results. However, we do not have the extensive detailed information that would permit us to propose a specific program of remediation. An unescapable conclusion is that inadequate funding for equipment, resulting in the use of out-

TABLE 8*
MEDICAL CARE
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

FY 1989	APPROPRIATION	10,542,500
	Supplemental Funds**	
	Current services and new programs	310,000
	Equipment backlog	100,000
FY 1989	Current Services Level	10,952,500
FY 1990	Annualization of Supplemental Funds	410,000
	Payroll related Increases	
	Federal Empl. Retirement System	50,000
	Annualization of 1989 PayRaise	70,000
	Annualization of 1989 FEHB	13,000
	Pay Raise 1990	200,000
	Within Grade Pay	50,000
	Health Benefits - 1990	40,000
	Misc. Payroll Items	15,000
	Inflation	200,000
	Facility Activations	200,000
	Capital Investment	
	Adjustments to 1989 Base	(154,700)
	Uncontrollable Workload Changes	
	State Home	4,900
	Miscellaneous	
	Property Rental	3,500
	AIDS	40,000
FY 1990	Current Services Level	12,094,200
	Extended Care Program	94,300
	Outpatient Workload Increase	100,000
	Postgraduate Inservice Training	6,000
	Geriatric Training Enhance.	1,400
	Equipment	100,000
	Decentralized Hosp. Comp. Prog.	25,000
	Prosthetics and Sensory Aids	4,000
	Anti-Substance Abuse	15,000
FY 1990	RECOMMENDED APPROP.	12,424,900

*EXPLANATORY NOTES MAY BE FOUND IN APPENDIX B.
**If supplemental funds are not appropriated,it would be necessary to include these amounts in recommended total

moded equipment, means the VA is prevented from providing up-to-date medical care in at least some instances and compromising quality care in others. The problem is compounded by the VA's reliance on useful lifetime schedules for equipment that do not adequately reflect technological obsolescence as a factor in the need to replace it. $100 million is a minimal essential partial down payment on this equipment backlog.

The environment described above creates an invitation to disaster and it is apparent to us that the VA medical care system cannot become any more efficient. As noted earlier, it is the firm belief of the Congressionally Chartered Veterans Service Organizations that the VA is experiencing an erosion of quality in the health care it delivers. Whether this diminishing of quality be real or perceived, the result is the same: veterans' loss of confidence in the VA health care system.

To offset this growing perception, it is essential that current services be clearly defined, that the necessary funding level be carefully developed, and that funds necessary to support the current base of operations be appropriated. Anything less contributes to further erosion of the resource base that is necessary to keep the VA health care system healthy. And, all of this must be accomplished within a carefully developed strategic and operational framework for the future VA medical care system.

Since approximately six months of the fiscal year will be remaining by the time supplemental funds could become available, we have recommended a $310 million supplemental to cover the medical care shortfall and $100 million to provide partial funds for the medical equipment backlog. A $410 million figure is also included in FY 1990 current services dollars to annualize these funds.

Because of payroll-related increases, approximately $440 million more will be needed to maintain the same level of staffing in FY 1990 (see Table 8). The 1990 pay raise is the largest component of this increase. In keeping with our principles, we recommend this pay raise be provided "up front"; this assures the VA agency all the needed funds for the personnel account. For non-payroll items, inflation is expected to require an increase of approximately $200 million in FY 1990 appropriations over the FY 1989 level merely to maintain the same level of program activity.

Activation of Facilities. During the course of FY 1990, activations of facilities under construction are expected to require approximately $200 million. This sum includes both the equipment and staff needed to operate these facilities during the part of FY 1990 that they will be open. Activation of facilities is a complex area for Independent Budget estimates due to the Administration's "embargo" on budget-related information prior to the release of the President's Budget. Since the essential information involves the completion dates for hundreds of projects, and such information is inaccessible, we are unable to form a fully independent judgment on the funding amount likely to be needed in FY 1990.

We have been told by VA officials that the slippage factor--i.e., delay of activation beyond the planned opening date--used by OMB over the last several years has been excessively high based on actual VA experience. There should be an end to sub rosa budget reduction made via arbitrary and excessive assumptions about the amount of slippage in activation dates. A more realistic slippage factor based on the last several years' actual experience would be more appropriate. As an offset to activation costs, there are the costs of capital investments made for FY 1989 activations. These costs do not recur in the FY 1990 base. This amounts to approximately $154 million.

AIDS Program Crisis. The impact of the AIDS epidemic on the VA health care system is already quite significant. All indications are that it will become more critical in the near future. Between 1981 and 1986, the VA cared for about seven percent of the national total of 40,000 cases of AIDS. The VA reports 1987 costs for treating AIDS patients vary from $18,000 to $24,000 per patient per year, with an additional $8,000 expense per patient per year for those on AZT therapy. Currently, the VA has 1,200 AIDS and Aids Related Complex (ARC) patients on AZT medication. These figures compare favorably to the private medical sector costs as reported by the Institute of Medicine, which are $50 thousand to $150 thousand per patient throughout the time span from diagnosis to death. Longevity figures vary. In a recent study of some 5,000 cases, 48 percent died within one year of diagnosis and 70 percent did not survive two years, although 15 percent survived 5 years.

There is a wide variation in predictions of future AIDS cases. The U.S. Public Health Service has predicted that there will be a cumulative total of 450,000 cases or more in the United States by 1992. Of this number, 280,000 will have died. Based on these figures, and assuming the VA's current workload of about seven percent of the national total continues to hold, the VA is likely to have been responsible for over 30,000 AIDS patients with an estimated 11,500 under treatment in 1993. It is expected that treatment then will be essentially the same as today, and that a vaccine will not have been developed by then.

As of September 30, 1988 the VA had cared for 5,073 AIDS patients. The VA FY 1989 AIDS caseload is projected to be 2,766 and the caseload is estimated to be 3,684 in 1990. Sixteen VA centers for the specialized treatment of AIDS have been identified along with three new laboratories for AIDS research. A $7.1 million investment in AIDS research is planned for 1990.

We wish to underscore the need to provide increasing additional funds to meet the high cost of this growing epidemic. Previous VA projections of workload had not included the AIDS epidemic, and additional funds to cover the patients it generates are necessary. The very substantial extra VA expense for the treatment of AIDS should not be absorbed in previously planned medical care funding; that funding is needed merely to meet the growing workload generated by the aging of the veteran population, and even these funds have been insufficient.

We therefore recommend that an additional $40 million be included in the medical care appropriation for FY 1990 for treatment of veterans with AIDS and ARC. This funding would include support for VA AIDS centers.

Combining all the previous adjustments plus the smaller ones shown in Table 8, but not discussed here, places the current services funding level for the medical care account for FY 1990 at $12.1 billion. It is important to recognize that while this figure is approximately a billion dollars more than the enacted FY 1989 appropriation, an increase of this magnitude is required merely to continue to provide the same level of services in FY 1990 as was provided in FY 1988 while correcting a number of serious threats to the quality of care being delivered by the system in that time frame. This one billion dollar increase exceeds the amount recommended to cover all of our program enhancements. In other words, the largest portion of the dollar increase that we recommend for medical care is not for program improvements but is required to simply keep pace with the existing base of VA health care activities and to ensure the capability of the VA system to provide timely, quality health care.

TARGETS FOR 1995: MOVING TOWARD THE FUTURE

Program Balance and Flexibility

The program/workload targets have been established in a manner that makes extensive use of the least expensive health care delivery modalities, which, based on expert medical opinion, should also provide the high quality care we seek for veterans. Since both the modalities and technology of care are dynamic, it is expected that the program mix and balance necessary to meet emerging health care needs of veterans and the workload/program targets must be viewed as flexible. Inefficient programs should be combined with programs with a nearby medical center where possible; if program workload necessary to maintain practice proficiency cannot be achieved, then the program should be disbanded or combined with similar programs in another medical center. One example is the open heart surgery program. Optimal efficiency and quality care are the goals to be achieved while moving toward the proposed targets.

Change in the Health Care Environment

In the private and public health care sector in the United States a gradual, but significant, shift toward non-institutional patient care is having a definite impact on the VA system. The response of the VA in adapting to this changing environment has been to expand outpatient care and to begin to develop more adult day care health programs, community residential care, and increased hospital-based home care. Model respite care programs and hospices are also a part of this trend. The VSOs expect this adaptation to continue in the future since this non-institutional environment may be suited to the needs of older veterans; in fact, the quality of their lives may be enhanced. Thus, expansion of the programs cited above is anticipated and encouraged.

Achieving Targets

In past Independent Budgets, program workload targets were established for 1990 and proposals presented for achieving the targets by using annual increments. The Independent Budget targets have been reassessed. The established program/workload goals are realistic and essential to meet the anticipated health care needs of veterans.

Our program/workload targets are substantially unchanged. Although 1995 program/workload targets have been established, it is important to note that, based on our projections, were the 1990 targets to be achieved, the VA system would be in a position to meet our projected workload for the early 1990s. In these years, planned movement toward the 1995 targets could then be easily accomplished with limited additional appropriations. The targets have been established based on in-depth analysis of VA information and care forecasting models that use VA inpatient and outpatient data files. The specific methods used to make the estimates and projections appear in the subsequent sections.

Most of the recommended program changes are expansions of extended care programs and health care services. As noted above, aging creates a need for particularly rapid expansion of extended care services, and outpatient care is being emphasized both because it has been constricted and because it is an economical modality of care. Most of the recommended program changes represent incremented steps toward targets for 1995. These targets are shown in Table 9.

Extended Care: Improve Extended Care Programs and Increase Workload - Cost $94 million and 1500 FTEE

The most complex program improvement we propose is in the area of extended care. We have emphasized non-institutional forms of care in this program improvement for several reasons. For one, they maximize veterans' independence and the extent to which veterans in need of care can

TABLE 9
WORKLOAD TARGETS

	FY 1989	FY 1990	FY 1995
VA Inpatients Treated	1,100,000	1,105,000	1,120,000
Contract Hospital ADC (Average Daily Census)	600	600	600
Staff Outpatient Visists*	22,700,000	23,700,000	25,000,000**
Fee Basis Outpatient Visits	1,880,000	1,880,000	1,880,000
State Home Nursing ADC	9,900	10,500	11,400
VA Nursing Home ADC	12,700	14,500	18,700
Community Nursing Home ADC	12,700	13,200	16,700
VA Domiciliary ADC	7,600	7,600	7,600
HBHC Programs - Contract and VA	73	172	172
ADHC Programs - Contract and VA	37	58	100
Geriatric Evaluation Units	80	172	172
GRECC Programs	10	15	25
Respite Programs	1	172	172
Hospice Programs	2	172	172
Community Residential Programs	125	172	172

*Includes dialysis

**Workload for proposed legislation for Category A Entitlement.

remain in familiar home and community settings, among relatives and friends. These results are desirable in and of themselves. Second, the emphasis on non-institutional long-term care helps rectify the imbalance in the VA system, which has large, long-established institutional long-term care programs (the nursing home and domiciliary programs) but less extensive non-institutional programs. Finally, but certainly not least important for this budget, non-institutional care is usually less expensive. Any given level of funding can bring extended care to many more veterans if it is used for non-institutional long-term care than if it is used for institutional care. The following program/workload improvements are proposed for extended care. Each is discussed below:

Establish Prototype Multilayered Long-Term Care Facility

The VA is in an excellent position to develop a prototype dedicated geriatric and long-term care center. We suggest at least one VA secondary care hospital, in geographic proximity to a tertiary referral VAMC, for total conversion of beds and mission to offer the following component elements: Nursing Home, Geriatric Evaluation Unit, Outpatient Clinics, Adult Day Care Center, Home Care Team, Respite Program, and a Hospice Program. The Long-Term Care Center should have included on its staff appropriate numbers of geriatricians, internists, physiatrists, psychologists, and social workers. There should be ample facilities for functional rehabilitation, physiotherapy, occupational and recreational therapy. Close cooperative and sharing arrangements should be effected with other community based long-term care facilities and programs.

Establish VA Hospital-Based Home Care (HBHC) Programs at Each VA Medical Center - Cost of $29.1 million

HBHC allows for the early discharge to their own home of veterans with chronic illness who (for the most part) are expected to remain bedbound or housebound. HBHC also reduces readmissions to the hospital. Patients and families find this program attractive because it preserves and supports the family unit by bringing health services to the home. A VA evaluation tested and proved the medical efficacy of VA HBHC. Already, the number of VA HBHC programs has increased from 30 in 1983 to 73 in 1988, and the study shows the wisdom of a continued rapid expansion. VA medical centers have realized the desirability of having HBHC programs, and most of the recent increase has been accomplished from existing resources, without add-on funding earmarked specifically for initiating HBHC programs. Our goal is to increase HBHC programs to a total of 172 by 1990. Full funding is provided for these programs. It is our belief that within the staff and dollars provided, the VAMCs should also provide for respite and hospice care at each site as part of an integrated approach to these three programs.

Establish a Formalized Respite Care Program at Each VA Medical Center - No net cost

Respite care enables an elderly or disabled veteran to be institutionalized periodically in order to allow a period of relief for the spouse or relatives who normally care for the patient. With this relief from ceaseless responsibility for care, the strain upon care givers is reduced, and they remain willing to provide care for the veteran, avoid institutionalization, for a longer period. Respite care programs produce gains at low cost. They make use of temporarily empty hospital beds and the care staff associated with these beds, making the net program cost little more than the staff time required for program coordination. Our strategy is to increase the number of programs to 172 in FY 1990 through a unified program that integrates HBHC, respite, and hospice programs. Funding is provided in the HBHC initiative.

Establish Hospice Capability at Each VA Medical Center - No net cost

The hospice program enhances the quality of life for veterans with terminal illnesses. Through use of the HBHC team, it allows many patients to remain at home among familiar surroundings and family. Hospice programs also include an inpatient palliative care unit for terminal patients who can not be cared for at home. As its name suggests, the objective of this unit is relief of symptoms and comfort for the patient. Hospices also provide bereavement counseling to patients' families. The cost is covered through the HBHC initiative.

Increase Adult Day Health Care (ADHC) Programs from 15 VA Programs and 22

Contract Programs to 27 VA Programs and 31 Contract Programs - Cost of $8 million

ADHC provides medical, rehabilitative, social, recreational, and health education services to veterans in a congregate setting during normal working hours. The provision of ADHC services enables veterans to live at home in a supportive environment rather than be institutionalized at a significantly higher cost of care. The number of ADHC programs has increased from 5 in 1983 to 50 in 1989. The recommended increase is part of a strategy to have 100 ADHC programs operating in 1990.

Establish Community Residential Care (CRC) Programs at Each VA Medical Center - Cost of $3 million

The CRC program provides residential care--including room, board, and limited personal care and supervision--to veterans who do not require hospital or nursing home care but who, because of medical or psychosocial health conditions, are not able to live independently and have no suitable family resources to provide needed care. There is no cost to the VA health budget for the care provided; veterans pay for this care, often with their pensions. Costs to the medical care appropriation are for supervision of the program, including inspection of residential care homes.

Establish Geriatric Evaluation Units (GEUs) at Each VA Medical Center - No net cost

GEUs provide comprehensive medical, functional, psychological, and environmental assessment to improve treatment and discharge planning for elderly patients who typically have multiple medical problems. Geriatric evaluation units function in hospital settings, caring for patients who have secondary problems that are detected during the hospital treatment of a target illness. GEUs also function in outpatient settings. The objectives of GEUs include improving diagnosis, usually by identifying significant disabling conditions that, if untreated, could result in greater amounts of institutional care; improving treatment and management of chronic illnesses and concomitant medical problems associated with illnesses; and reducing inappropriate placement in long-term care institutions. Controlled studies show that GEUs often more than pay for themselves by reducing institutionalization of the patients they serve. Our proposal calls for all VAMCs to have GEU units by 1990.

Increase the Number of Geriatric Research, Education, and Clinical Centers (GRECCs) from 10 to 15 - Cost of $13.5 million

GRECCs are centers of excellence designed for the advancement and integration of geriatric and gerontological research, education, and clinical achievements into the total VA health care system. An expanded GRECC program will allow the VA to maintain its clinical and educational leadership role in dealing with the problems of aging. It will foster the development of new approaches to care that meet the twin goals of improvement in care and cost containment. The timetable with respect to GRECCs has slipped, and our current goal is to have 25 GRECCs, the maximum number currently authorized by statute, by 1995. This will come close to having a GRECC in every one of the VA's medical districts.

Increase the Nursing Home Census by Approximately 3000 - Cost of $45 million

Despite the preceding major expansions of non-institutional extended care, an increase in institutional long-term care remains necessary to serve the growing number of veterans with such severe functional limitations that they cannot be cared for in a non-institutional setting.

Our targets for nursing home care are based on a new analysis grounded in the 1985 National Nursing Home Survey[3]. Data from this survey first became available last year, and the VA's planning for nursing homes has not yet fully incorporated this important new source of information. The 1985 survey shows that nursing home use rates for each age group are no longer increasing, contrary to the pattern found in earlier surveys. (The most recent earlier survey covered 1977.) Our planning therefore assumes a constant use rate for each age group of veterans, much as shown in Chart 4 on page 69, with future increases in the number of veterans in nursing homes resulting only from aging of the veteran population. The new survey also shows that the number of veterans in nursing homes under VA auspices was approximately 20 percent of all veterans in nursing homes; our targets assume a continuation of this 20 percent rate. In addition to VA-owned and operated nursing homes, this 20 percent of all veterans in nursing homes will be accommodated (1) in state nursing homes for veterans, for which the VA provides construction and operating subsidies; and (2) in community nursing homes, with which the VA contracts to provide care for veterans.

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[3] While the National Nursing Home Survey is recognized as the authoritative source of data on nursing homes, one should bear in mind that nursing home utilization during the period of the study was constrained by external factors that may become irrelevant in the coming decade. These factors included moratoria in many states on the construction of additional nursing homes and federal budget cuts in Medicaid.

Much of the VA planning for an increased nursing home census has been based on the premise (advanced by OMB) that the large majority of the increase should be undertaken in the state and community nursing home programs that the VA supports, since their costs to the VA are lower than those of VA-operated nursing homes. A commonly stated goal is for 40 percent of the census to be in community nursing homes (up from 39 percent in 1987), 30 percent to be in State homes (up from 27 percent in 1987), and 30 percent to be in VA nursing homes (down from 35 percent in 1987). Such plans falsely assume that major expansions will occur in available State and community nursing home beds.

We are skeptical. Primarily as a Medicaid cost-control device, many states have frozen or severely restricted construction of new nursing homes. In this climate, availability of more beds for VA-sponsored patients is questionable. Any increase in VA census is likely to require displacing other patients, which will create strong resentments in the community. Moreover, an increase in VA census is likely to create a bidding war against Medicaid, with the probable result being higher costs to the federal government for both Medicaid and VA health care. As regards the state home program, states have shown only a limited willingness to accept VA's construction subsidies for state veterans nursing homes, since most of the cost of operating these homes is borne by state budgets. A rapid increase in the capacity of state veterans nursing homes seems doubtful.

Our planning is based on the maximum expansion that currently seems feasible in the state and VA-operated nursing home programs. The community nursing home program should provide the additional places needed. Chart 6 shows the VA-sponsored nursing home census included in our plans.

In the near term, it is necessary for the VA nursing home program to incorporate the beds added by nursing homes now in the construction "pipeline" and also to grow through conversion of approximately 500 to 1,000 VA hospital beds a year. The FY 1989 VA budget called for the conversion of 289 beds. Hospital administrators' and clinicians' attitudes hostile to conversion must be overcome by VA top management and the targets we recommend for conversions should be considered key objectives for the VA system.

In spite of promises to the contrary, the VA has been derelict in converting sizable numbers of their excess hospital beds to nursing home units. The private hospital industry has been more circumspect. Private-sector conversions provide a role model for a reluctant VA to follow.

The American Hospital Association (AHA) reports that between 1983 and 1985, the number of hospital-based nursing facilities grew nearly 50 percent. In 1986, 15 percent of the hospitals surveyed by the AHA expected to add long-term care beds. These statistics don't even reflect hospitals' acquisition of free-standing nursing facilities.

We recommend a conversion goal that is this flexible and modest because the opportunity for conversion is often more limited than it first appears to be. There is a geographic problem in that excess acute care beds are not always available for conversion in areas where more nursing home beds are needed. Moreover, nursing homes require large, contiguous blocks of space, not a few odd beds here and there, and also require recreational and social meeting space. For this reason, we recommend 60-bed blocks as the smallest unit for conversion to nursing home use.

It is important to note that the conversion of empty beds from acute hospital care to nursing home use does not free up enough staff and funds for use in providing the nursing home care. The inpatient hospital care census requires more staff per patient because of more intensive care, which permits the inpatient hospital census to be lower. Moreover, the hospital staff is also occupied by the increasing number of outpatients being seen. Therefore, partial staffing and funding still are provided for nursing home bed conversions.

For the longer term, we propose that 500 VA nursing home beds be added to the system annually through the completion of four new 120-bed nursing homes every year. Work on these new nursing homes must start now--appropriations for four of them are included in our FY 1990 construction budget--because it takes several years from initial construction planning to completion of a VA nursing home. (The construction program required by VA nursing home expansion is described later, in the chapter dealing with construction.)

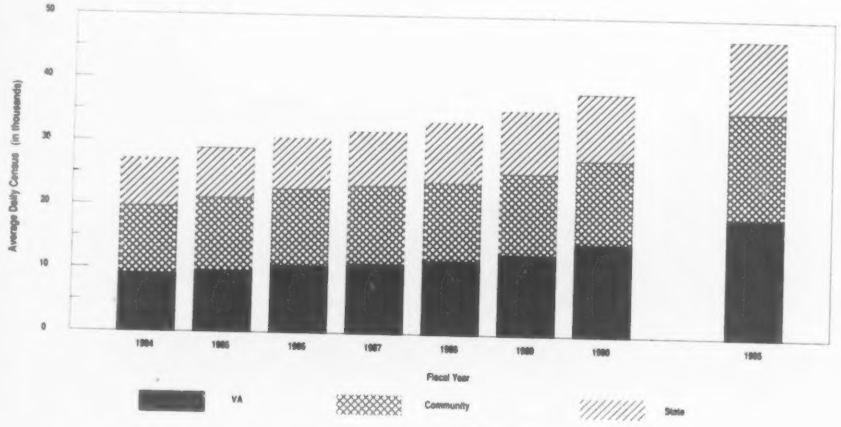
As shown in Table 9, our specific plans call for increasing the census in VA-operated nursing homes from approximately 12,700 in 1989 to some 14,500 in 1990 and 18,700 in 1995. The staff associated with the 1990 increase (approximately 600 FTEES) and the associated cost (approximately $30 million) are shown as part of our extended care initiative in Table 9. To meet the overall needs for nursing home care, we are also proposing an expansion of the community nursing home program from an average daily census (ADC) of approximately 12,700 in FY 1989 to 13,200 in FY 1990, at a cost of approximately $13 million, and an expansion of the state veterans nursing home program to an ADC of 10,500--an increase in census of approximately 600--at a cost of $5 million. (VA budget accounting, which we have followed, counts this $5 million for expansion of the state veterans nursing home program as part of the current services increase, as shown in Table 8.)

Chart 6 shows the increase in the census in the three VA-sponsored nursing home programs that have occurred in recent years and the increase that we recommend for the future.

Hold Hospital Inpatients Treated Constant

Recent statistics concerning VA hospital inpa-

Chart 5
VA Nursing Home Care Census
FY 1984-1995



tients are shown in Chart 6. Hospital inpatient workload has been projected using a model developed by the Independent Budget staff. The model is population driven and uses age-specific length of stay, based on a DRG-specific analysis of VA length of stay compared to private sector length of stay (from the National Hospital Discharge Survey). This model does not allow for a hospital length of stay to exceed 100 days for any hospital stay--such excess hospital days are assigned to nursing home care. In general, the model projects an increase in the number of patients treated over the next several years with average length of stay continuing to decrease (see Chart 7). However, the projected number of patients treated may decline when the experience of 1988 and 1989 can be included to account for the extensive shifts that have been made from inpatient to outpatient care. For this reason, we are not projecting any significant increase in the inpatient hospital workload for FY 1990, although there are projected increases of some significance for the early to mid 1990s.

Our analysis of the trends in VA health care and the application of our models to the VA data files lead us to conclude that occupancy of VA hospitals (see Chart 8) has peaked. If the inpatient hospital occupancy has not peaked, it is due to the lack of consistency in patient treatment modalities across the system. This being the case, it is our estimate that the number of hospital beds needed for the care of veterans is such that our recommendations for conversion to nursing home care are sound and that the opportunity exists, especially in urban settings with a number of VA hospitals, to establish multilayered long-term care facilities described on page 75.

Expand Outpatient Care to 23.7 Million Visits – Cost of $100 million

Recent data point to the VA's success in shifting the balance in the care it provides toward outpatient care, which is less expensive than inpatient care. Chart 9 presents the outpatient visit rate, which has increased for most age groups between FY 1986 and FY 1988. Chart 10 shows that the growth in "staff" (i.e., VA-provided) outpatient medical visits was approximately seven percent in FY 1988, twice the growth rate seen in the years before 1987.

Based on the rapid growth achieved last year, and in support of a still further shift to the less costly outpatient care modalities, we recommend the VA plan to provide 23.7 million outpatient medical visits[4] in FY 1990.

Chart 6
VA Hospital Patients Treated
FY 1980-1988

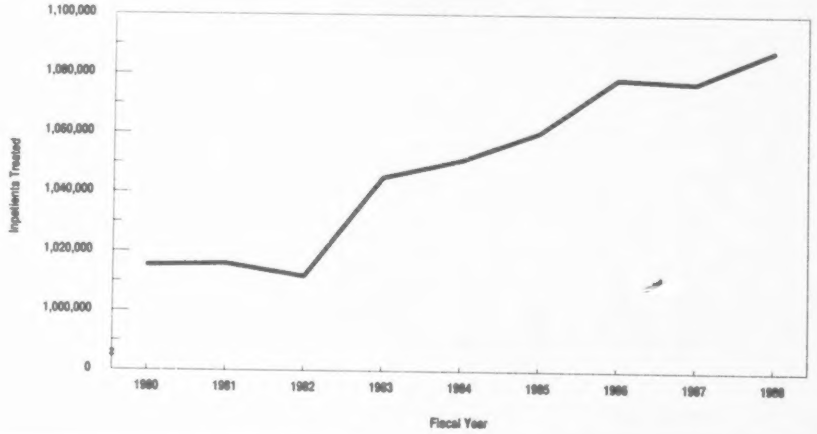


Chart 7
VA Hospital Length of Stay
FY 1980-1988

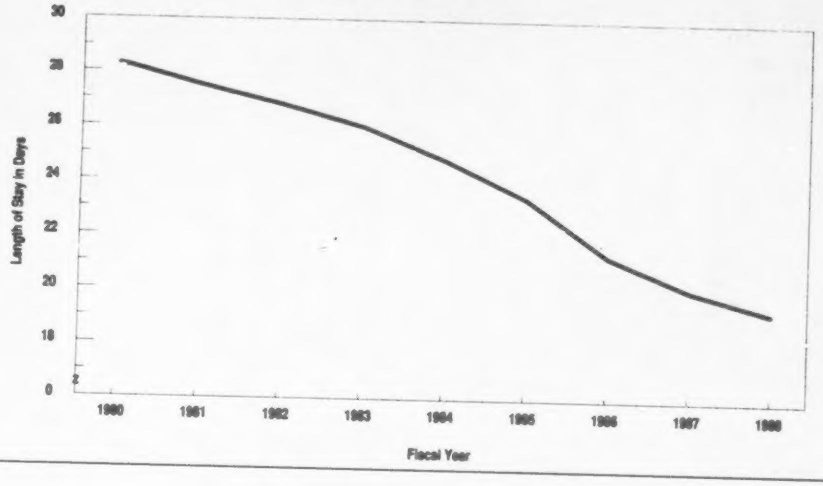


Chart 8
VA Hospital Occupancy Rates
FY 1980-1988

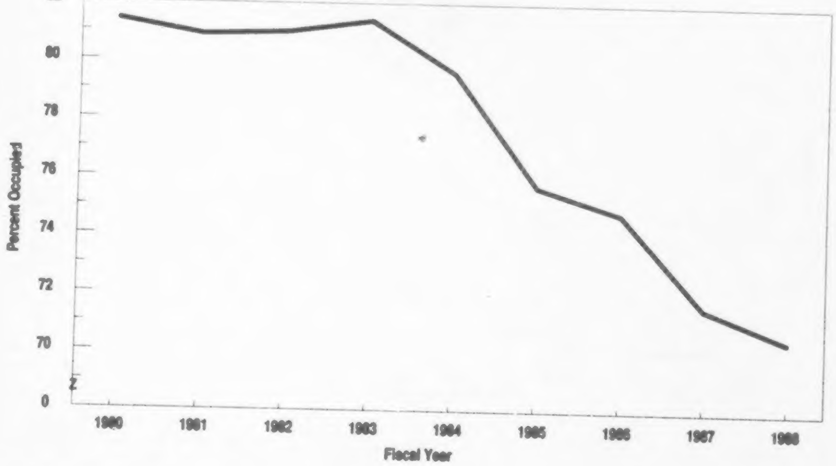


Chart 9
VA Staff Outpatient Use Rate
FY 1987 and 1988

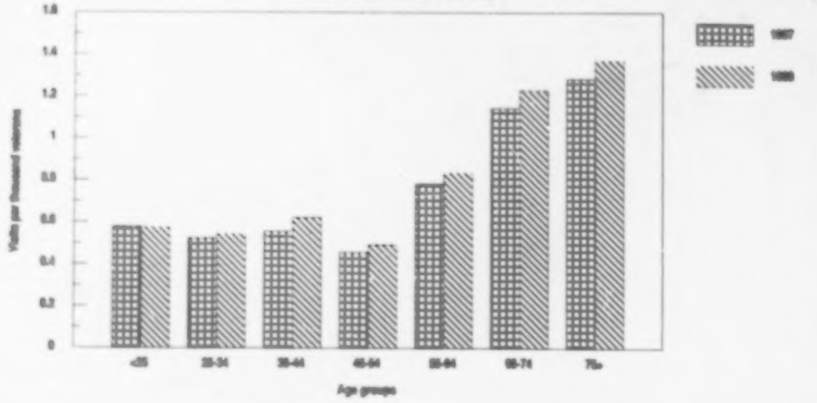
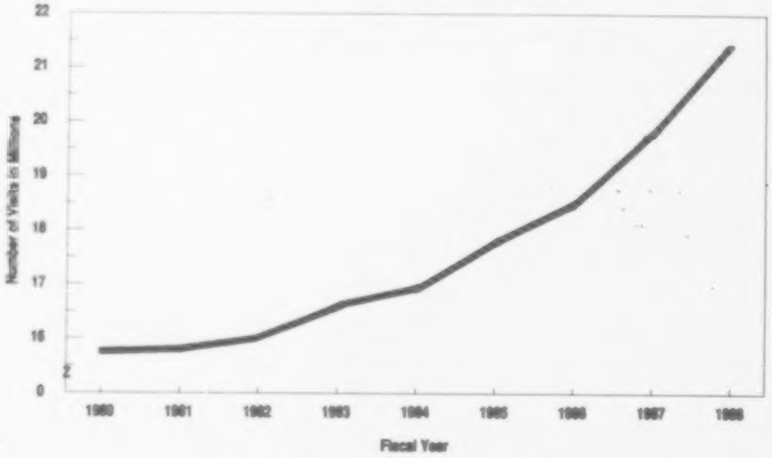


Chart 10
VA Staff Outpatient Visits
FY 1980-1988



Partially Fund Replacement Equipment Backlog

Recent communications with the VA provide evidence that the VA will have a backlog of object class 31 and 32 replacement equipment of close to $1 billion by the end of FY 1989. This figure has been very difficult to ascertain and it has taken repeated effort by the Independent Budget staff to collect information concerning the backlog. It is also clear that central information is not available on new additional equipment that is requested by the medical centers and is denied at levels above the medical center. The VSOs have included $200 million in the FY 1989 supplemental and a $200 million FY 1990 appropriation request for equipment. If this supplement of funding is not made available, the amount needs to be incorporated in the FY 1990 appropriation. In addition, the VSOs feel that an additional $100 million should be funded in FY 1990 to provide the first installment in a multi-year appropriation that would reduce the backlog of needed medical equipment over the next 3-4 years.

Pursue the Implementation and Evaluation of the Homeless Chronically Mentally Ill (HCMI) Veterans Program

This program established by P.L. 100-6 and extended through FY 1988 by P.L. 100-71 and P.L. 100-322 is designed to help those who are least able to help themselves. The legislation authorized $15 million but Congress did not provide specific appropriations for the program in FY 1989. The supplemental funds requested under the current services discussion includes funds for the HCMI program. Therefore no funds are requested in this portion of the budget.

Since its inception it has had an intake of 10,524 veterans through March 1988 in 43 metropolitan areas. These veterans who were identified in shelters, soup kitchens, abandoned buildings and on the streets have extensive need for care since 80 percent of those assessed at intake presented either a general psychiatric or substance abuse problem. Twenty-nine percent of those veterans had medical examinations which indicated that 88 percent of them had a diagnosed illness. Of importance is the judgment that 60 percent of the medical care need could be provided on an outpatient basis.

This unmet need is a major challenge to be met and is further discussed on page 88 under Unmet Needs Survey For more detail see Appendix C, the Veterans Administration report to the Congress on the Homeless Chronically Mentally Ill Veterans Program December 1988.

Pharmaceutical Unit Dose Program

A program was initiated around 1980 for installation of the "unit dose" system in all VA hospitals for dispensing of pharmaceuticals. Incremental funding since that time was discontinued in FY 1987. Fifty VAMCs are still waiting for the resources to acquire the unit dose capability for increased patient safety, cost economy and security from theft in the handling of inpatient medications.

Although we are not recommending additional funding for this purpose in this austere budget year, we are constrained to note for the record the cessation of this worthy program is yet another example of regression due to underfunding. A completion date for installation of unit dose capability in all remaining VA hospitals should be targeted for the not too distant future.

STRENGTHENING THE MEDICAL CARE PROGRAM

It is the recommendation of the VSOs that steps must be taken now to move the health care system forward in response to clearly changing health care needs of veterans and to the shifting modalities of care. The changes we recommend will address many of the problems that currently exist and anticipate future needs.

Revise the VA's Health Care System Planning

The Department of Medicine and Surgery is facing a funding crisis in FY 1989 and outyears. After examining events related to this crisis, the authors of this Independent Budget conclude that the MEDIPP process, the VA health care system's planning program, had not succeeded in communicating program and funding problems and providing alternatives for their solution. This is supported by the fact that the Chief Medical Director convened a task force to consider options for dealing with the "funding shortfall." The "shortfall" did not suddenly happen in the spring of 1988; it was the culmination of events that took place over a number of years, due partially to expansion of program activities outside the MEDIPP process. However, even the Medical Districts have used the MEDIPP process to justify program expansion rather than assess the current situation and develop strategic and operating plans to address the fundamental issues. The Chief Medical Director (CMD) apparently has no faith in the current program, and, based on our knowledge, neither do the Regional Directors--the VA health care system's line field officials. We fear that the MEDIPP program will be abandoned by the Department; however, we also know that planning is essential to the management of the VA health care system in a time of stress and resource constraints. Based on this assessment, we recommend that MEDIPP be restructured, since without strong central direction the field will plan for an ever-increasing resource base and the Central Office will ignore the input, even the input designed to communicate problems and the alternatives to their solutions.

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*The data on outpatient visits include same-day dialysis treatment, which the VA had previously counted as inpatient episodes.

A more critical problem presents in the relationship between the Facility Development Plans (FDP) and MEDIPP. Since the FDP derives its future direction from MEDIPP workload and program projections, MEDIPP must be realistic and accurately reflect the direction of the health care system. MEDIPP must produce a valid and reliable product since billions of dollars in construction funds are dependent on the strategic and operating products of medical care system planning.

We recommend four steps in the planning process.

1. Strong central strategic and operations direction from the Chief Medical Director.

2. A directive to the Regional Directors to develop workable alternatives for achieving the strategic direction of the Chief Medical Director and operational direction defined through a carefully executed MEDIPP process.

3. A set of decisions on implementation feedback provided to the Regional Directors and District Directors by the central office.

4. A strong, valid, reliable link built to the Facility Development Plan.

Data bases and models to assess alternatives should be developed by district teams to support the entire planning program. The program should be supported with the current district/regional staff and a core strategy group in the central office that has extensive experience in corporate hospital and hospital system planning. The name of the game is health care service to veterans: efficient, cost-effective, high quality care. The planning, resource allocation, and quality of care programs must mesh in a symbiotic fashion to meet the challenges of the 1990s. This symbiosis is sadly lacking in the VA central management program.

The VSOs anticipated the crisis, erosion of the quality, and unfunded workload. It seems to these authors that the Department of Medicine and Surgery and the MEDIPP process must also have anticipated these same conditions and should have posed a solution long before a crisis emerged. Much more attention must be given to strategic direction and planning for the future.

Human Resources Development

Staffing Shortages. Staff shortages of health professionals in the VA have been a recurring problem for some time. It has now reached critical proportions with scarcity of allied health personnel second only to the shortage of nurses.

Hospital labor shortage is in fact one of the most pressing issues facing the nation's health care system. It is not confined to the nursing profession nor to particular locales. The whole field of rehabilitation, for example, is faced with a short supply of personnel, including physical therapists, occupational therapists, speech and hearing therapists, and laboratory technicians. The intensity of private sector competition for recruitment of these scarce professionals has the VA at a distinct disadvantage.

Several thousand VA hospital beds are allegedly closed for want of necessary staff. Taking note of this detriment, the FY 89 Independent Budget urged the implementation of a human resources plan for all employees to create the kind of environment that recognizes their professional contributions, assures competitive pay scales, provides for professional growth, and accommodates their personal needs. Congress in its concern has provided the VA with additional tools for recruitment and retention of both nurses and technicians. Scholarships and tuition reimbursement in exchange for obligated service commitment, together with authority for special incentive pay and child care centers, if properly utilized, should enable the VA in due time to at least partially alleviate these shortages.

DM&S is to be congratulated for establishing a new Recruitment and Retention Office charged with the implementation of a "whole array of things which need to be done." They have announced their intention to request of the Office of Personnel Management a realignment of occupational guidelines and provide the VA with greater flexibility to establish pay rates for scarce health professionals. We heartily endorse this effort. The current restrictive civil service schedules have the VA health care managers at a disadvantage in competing with the private medical sector for candidate recruitment and retention.

It is very apparent that salaries and benefits for nurses in particular must be increased. The VA identifies at least 3000 beds closed for lack of nursing staff. The national shortage is not a transient phenomenon. The federal government predicts a national shortfall of one million nurses by the year 2000. In this regard, the VA, as the nation's single largest health personnel production resource, should be the vehicle for nurse graduate production beyond the VA's own staffing need.

Unfortunately, this VA staffing shortage may soon be compounded by a shortage of physicians. In 1990, when retirement income calculation will incorporate the entire special incentive bonus pay, a large exodus of doctors is anticipated. Approximately 7,000 full-time and 5,900 part-time physicians currently are employed in the VA. Taking a measure of just the full-time cadre alone, 2000 (or 28 percent) will become eligible for retirement by July of 1990. Assuming a normal retirement rate of something less than 15 percent, approximately 300 of these physicians would retire in late 1990 or early 1991. This is the "best case" outcome. Given the added incentive of an individual's average additional $6,000 or more in retirement income, the system may realistically lose as many as 1,000 full-time physicians. Among those numbers are 77 of the 157 Chiefs of Staff. If the majority of those do retire in that same time period, DM&S would experience a critical shortage of clinical managers at their facilities. A crash recruitment for that volume of physician replacement will not be easy. Moreover, the availability of candidates is likely to diminish during ensuing years.

There is a need for both short and long-term attention to this problem. Congress has already been alerted to the serious drain of physicians from the military services. In response, legislation is pending to upgrade military medical officers' incentive pay, the yearly amount of this special bonus not to exceed a 48-percent increase for any individual--the amount of increase in the Consumer Price Index since 1980, the year special pay legislation for military medical offices first was enacted. The same special pay provision was provided VA physicians in 1979. Because no inflation adjustment has since been made, a progressive discrepancy has developed between income levels for federally employed physicians, those in academia, and especially those in private practice. Lacking corrective legislation, physician recruitment and retention by all federal health care services will be increasingly compromised.

Anticipating the future, serious consideration should be given to VA participation in a program similar to the Health Professions Scholarship Program (HPSP), from which the military medical services have long derived a majority (80 percent) of their annual physician input. It would seem that in the Health Professions Educational Assistance Program of Public Law 100-322, Section 216, Congress has given authorization to the VA for such medical school scholarships. Only an appropriation is needed. Specified in that law is the mandate to require, hereafter, payback through service commitment. That same provision should certainly also be immediately applied to current VA postgraduate specialty fellowship programs.

We note, parenthetically, that the HPSP program for medical/osteopathic students under the auspices of the Department of Health and Human Services received no appropriation in FY 1989. That scholarship program peaked in FY 1978 when 3,150 new awards were made along with 1,907 continuations. This DHHS program was finalized in FY 1988 with 36 awards. The program close out was no doubt in line with a presumption made several years ago of a coming "glut" of physicians, references to which can be found in the Congressional Record.

Circumstances are now developing that would negate the prediction that the nation will have an excess of physicians in coming years. They include such factors as the increasing tendency for physicians to enter corporate structures on a salary basis with shorter work week involvement; the growing percentage of female physicians with fewer hours devoted to their professional career; the anticipated reduction in resident house staff work hours; the increasing involvement of physicians in administrative activities and a variety of nontraditional clinical activities that currently occupy a physician's time; an acceleration of the physician labor-intensive technology; the increasing health care impact of the aging citizenry; the AIDS epidemic, and, finally, the decreasing numbers of medical school applicants (20 percent reduction between 1981 and 1987).

To address the physicians' staffing shortage problems, the VSOs recommend consideration for:

o Utilizing HPSP for recruitment of physicians in the VA.

o Providing legislative authority and funding to upgrade VA physicians' special incentive pay to a level correcting for inflation adjustment since the 1979 bonus enactment.

Crucial to both recruitment and retention of health professionals are the pre- and post-employment education and training programs.

Education and Training

Staffing shortages in VA health care facilities and the national scarcity of nurses and allied health personnel makes the VA education programs the more essential. Annual budget cuts in Medicare for direct and indirect hospital residency funding also make medical school affiliates more dependent upon the VA medical and dental training programs. Congress has recognized this impact by appropriating in the FY 1989 budget increased funding for trainee stipends and the VA Tuition Support Program.

The VA has long been known as the nation's single largest health personnel production resource. Certainly, the time has come when this teaching effort could be more specifically focused on alleviating the critical staffing shortages within DM&S. The option of expanding the scholarship program to include medical school scholars has been alluded to.

Additionally, the VSO authors recommend the following increments for further strengthening the VA's education and training effort.

Reestablish the Health Manpower Training Grant - cost of $5 million

This proposal was originally incorporated in S-2011, but later eliminated. It would provide awards to health manpower training institutions with VA medical centers to increase training capacity for allied health professionals in fifteen shortage disciplines. Pilot funding of $5 million is requested.

Authorize and Fund Associate Degree Program - cost of $8.4 million

This program would exploit the potential source of future registered nurses and allied health personnel from within the ranks of existing VA employees. Young, low salaried candidates would be selected for career development to pursue associate degree nursing and allied health education on a full-time basis. This is in contrast to the ongoing Tuition Reimbursement Program for limited subsidy of part-time schooling. This associate degree educational program is a DM&S proposal which has thus far failed to receive concurrence and budget support from the Office of Management and Budget. Candidates would receive full VA salary during the two-year education schedule along with reimbursement for tuition, books, and related fees. This would require two years of obligated service pay-back for each year of academic support. A cost of $8.4 million is projected.

Increase Postgraduate and Inservice Training (PIT) - cost of $6 million

Budgetary support for inservice continuing education has so declined that the PIT purchasing power is now less than 40 percent of what it was in 1978. The Independent Budget last year recommended in vain that this fund be doubled to $20 million. We are requesting that at least a 60 percent increase be granted to regain the commitment of ten years ago. Employees professional growth is an essential element in the maintenance of quality health care, as well as in recruitment and retention of personnel. The need for postgraduate and inservice training is now all the greater because of new technology and treatment modalities, clinical computerization, the increasing impact of aging veterans, and staff personnel shortages and turnover. A cost of $6 million is projected.

Fund AIDS-Related Training Programs - cost of $3 million

The need for special funding to cover the high cost of medical care for increasing numbers of veterans suffering from AIDS and AIDS-Related Complex has been recognized in past budgets. The attendant demand for VA educational support to AIDS care providers deserves equal support. DM&S has designed a multi-phase training program with varied elements for HIV prevention counselors; training of VA health care providers, including interdisciplinary teams, to conduct AIDS education activities; and support for AIDS research fellowships. We recommend a specific appropriation of $3 million for support of this special academic initiative.

Enhance Geriatric Training - cost of $1.4 million

We recommend continuing increases in the numbers of geriatric medicine residencies for physicians and dentists to meet the challenge of the growing aging population. We estimate a cost of $1.4 million.

Employee Welfare and Morale

The newly established Recruitment and Retention Office in DM&S is in an excellent position to work with and coordinate the efforts of all sections and services contributing to the welfare and morale of employees. Much remains to be done if the VA is to match the private sector hospital's accommodation of the personal needs of their staff. The VA now has the authority to expand in-house child care centers, shift differentials, and provide transportation and parking arrangements. Career counseling should be more available and opportunities advertised for professional growth. Sabbatical leaves where deserved and indicated could be more liberally offered.

Quality of Care

The assurance of and access to quality health care in VA facilities has for several reasons become a major concern, with a of priority ranking equal to such issues as the impact of the aging veteran, the current unmet health care needs of entitled veterans, and the implication of continued federal budget austerity.

It is of no less concern in the private medical sector due to the continued cuts in Medicare, the similar cuts in Medicaid appropriations, the stringent provision of medical service stemming from the inadequacy of hospital operating margins, and the loss of access to health care for increasing numbers of uninsured. Restructuring the health care system under the competitive medical market has resulted in patient movement to the out patient arena and new reimbursement incentives have been directed at the provision of less care rather than more care.

For many decades, there has been a peer review type monitoring of medical care within hospital staffs, but without the participation or critical observations of patients or third party payers. But now the escalating cost of care has directly and indirectly sparked the consumer demands for assurance of quality.

The term "quality assurance" is in most usage a misnomer. The quality of medical care cannot be assured by an investigative process. Quality assessment is a more appropriate term for monitoring the quality of medical care. The triad commonly used to assess quality focuses on the structure, process, and outcome of care. Outcome measurement is a recent addition, borrowed from industry's long-standing focus in quality control on evaluating the product itself.

Our traditional methods to assess both structure and process are crude and incomplete. The structure of care encompasses the resources and organizational arrangements in place to deliver care, such as medical personnel, facility space and functional design, and the presence of peer review committees. The quality of care a patient receives is based on the assumption that better performance is directly related to specific structural characteristics. This has been the primary focus of the Joint Commission for Accreditation of Health Care Organizations (JCAHCO).

The process of care refers to the activities of physicians and other health care personnel engaged in their practice. Here the concern is the difficulty in evaluating accepted medical procedures and the weak link between the process of care and patient outcomes. These outcome models should develop into statistical profiles to measure both quality and efficiency by means of analyzing aggregate data. Multiple organizations including the JCAHCO are developing such instruments. The Veterans Administration has a task force exploring the same potential. The Veterans Administration should demonstrate unique expertise in defining and assessing quality care in such areas as prosthetics, geriatrics, spinal cord injury, and rehabilitation. The automated Patient Treatment File of the DM&S is one vehicle in place for retrieval of such data.

It must be understood that fully developed outcome statistics cannot be translated directly into quality measures. The statistics must be interpreted. It will take some time before valid instruments are designed, data needs determined, and model validity tested. The key issue in this full development of outcome models is a long-term commitment of resources to maintain data bases and professional staff devoted to their analysis and management. It should be noted that major industries invest 3-5 percent of their budgets in quality control, assurance, and quality management programs. The VA's ultimate program is bound to be expensive. That must be an explicit factor in budget appropriation and in any resource allocation process.

Meanwhile, the VA's quality management program, MEDIPRO (Medical District Initiated Peer Review Organization) is a system of assessment based outside the medical facility and augmenting the internal system of peer review.

In P.L. 100-322, the Congress has provided guidance for the enhancement of the DM&S quality control effort. The CMD has taken further initiative in pursuit of outcome evaluation models. Because of the inevitably protracted evaluation system development, we urge Congress to request annual progress reports on this very important program by the Department of Medicine and Surgery.

Both the Congress and the VSOs will be following, with vested interest, the progress of a four-year on-site service review of 75 VA medical centers which has now begun in Illinois, Michigan, New Jersey, New York, Ohio, Texas and Wisconsin. The review, under VA contract, will result in recommendations on "how to boost the quality and cost-effectiveness of VA health care services."

Resource Allocation

There is growing discontent in the VA Health Care system with the Resource Allocation Model (RAM) as available funds become tighter. There is also a concern raised in the Independent Budget that use of the RAM for psychiatry is most inappropriate and results in shifting needed psychiatric dollars to medicine and surgery. Since the RAM is an available objective method for distributing funds throughout the system, we recommend that it continue to be used until more appropriate methods can be devised. The fundamental problem with the RAM is that it invites the challenge to "beat the system" and this in turn invites changes in the RAM to address the cleverness of hospital managers. However, it is time to accept the model as a practical but admittedly imperfect tool. Failure to use an objective method of fund distribution will ultimately result in changing the focus and mission of medical centers to be consistent with management's perception of what is needed. This approach is acceptable to the VSOs only when strategic and operations plans have been developed for the system and are available to VSOs and the public in general.

Continued use of the RAM, however, requires that some management controls on its use be implemented to improve resource distribution including:

o Establish the funding for psychiatry at the FY 1987 level and distribute the funds to psychiatry on a capitation basis.

o Establish a level of medical activity for each medical center in the system, (e.g., primary, secondary, tertiary, and a program mix) and fund only those functions carried out within the approved mission unless there has been central office approval for a change in activity, program, or mission.

o All procedures currently carried out on an outpatient basis be reimbursed to all medical centers at the outpatient reimbursement level whether or not they are carried out in the ambulatory setting.

o Through MEDIPRO, carefully monitor patient admissions and transfers between wards to control the gaming that could occur by taking advantage of multiple admissions/ transfers to treat multiple conditions and other factors as prescribed in DM&S Circular 10-88-22.

o Remove all caps on transfers of funds between stations and assure equal access to care.

Beneficiary Travel

The VSOs note with concern that, although in FY 1989 the Congress specifically authorized reimbursement of veterans for their travel to and from a VA health care facility, the VA has persisted in combining these funds that should be available to individual veterans with interfacility transfer funds. This combined accounting procedure makes it impossible to determine the amount of funds actually made available to veterans for travel. Therefore, we recommend that beneficiary travel funds appear in the budget as a separate item not coupled with the cost of interfacility transfer of patients, thereby protecting the erosion of those funds to interfacility transfer. We further recommend that the Veterans Affairs Committees of the Congress require annual reports accounting for beneficiary travel expenditure of DM&S.

Unmet Needs Survey

The unmet medical care needs of entitled veterans must be fully identified. We are genuinely concerned about all Category A veterans whose need for medical care is for one reason or another not being met. These veterans fall into three groups; first, veterans who need outpatient care but, under current rules, are only eligible for inpatient care; second, homeless or otherwise deprived veterans who can only be identified and served through outreach programs; and, third, veterans with unmet medical needs who are unaware of their VA entitlement or who, because of previous discouragement, no longer seek VA care.

An example of the first group is a severe diabetic or a hypertensive patient who has been stabilized but requires continuous monitoring. Glaring examples of the second group are being encountered in the recently created national program of community-based treatment for Homeless Chronically Mentally Ill (HCMI) veterans. Forty-three VA Medical Centers are now actively involved in this program, which consists of an outreach and care management component, medical and psychiatric evaluation, and contract care for psychiatric residential treatment. From May 1987 through March 1988 over 10,500 were contacted resulting in approximately 2,400 admissions.

The veterans seen as a result this program were found in soup kitchens, abandoned buildings, streets, and shelters. They have an exceptionally high prevalence of both psychiatric and medical illnesses, even for a homeless population. They are poor, socially isolated, and mostly unemployed. Of the initial 10,500 contacts, 30 percent served in combat and 1.5 percent were ex-POWs. Of those who received a formal psychiatric assessment, 9.3 percent were diagnosed as having combat-related post-traumatic stress disorder. It is conservatively estimated that veterans constitute half of all homeless Americans, and that there are hundreds of thousands of homeless veterans. The data are presented to illustrate the critical need for medical and socioeconomic assistance on the part of a veteran group that would not otherwise be identified in even the most intensive demographic survey, since surveys are based on people's residences or telephone numbers, and these veterans are homeless.

If the Means Test Report is properly modified, as suggested in our last year's Independent Budget and recently recommended by the VA Inspector General (IG), data on the first category of veterans with unmet need--those needing outpatient care but turned away because they are only eligible for inpatient care--should be made available. It now appears that planned VA actions, in modifying AMIS segments 320-323, will provide this information in FY 1989 if carried out. The second veteran group with unmet need--the homeless--will, over a period of time, be identified if VA outreach programs for homeless veterans are given permanence and priority. Valid data on the third group with unmet need--those unaware of their entitlement or discouraged from using the VA--can be captured only by a well-designed and carefully conducted survey.

We have reason to believe that there are large numbers of veterans in this third group, veterans who have abandoned or have been abandoned by the medical care system that was deigned to care for them. Although there are (and have been) many sound surveys to acquire good data about veterans and their needs, none pursue the information we think to be essential. We reviewed the Survey of Veterans (SOV) III and found that there is not sufficient attention given to probing for information about health, health care, and veterans' health care needs. The SOV III follow-on surveys by the VA concerning service-disabled veterans and medical care users do not focus the full population of concern to the VSOs--they omit veterans outside the system who are not service-disabled. Other possible data collection mechanisms such as over-sampling and in-depth questioning through the National Medical Expenditures Survey (conducted by the National Center for Health Services Research, DHHS) have not been used by the VA. We suspect that one reason survey information on unmet health care need is not available is that federal surveys must be cleared by OMB; the pursuit of information on unmet need might show needs that would not support OMB's budget reduction goals.

We recommend that a survey be designed and administered to a national sample of veterans for the purpose of identifying their health status, their health care needs, the sources through which these needs are met, their unmet health care needs, and the potential the VA offers for fulfilling these unmet needs. The survey should be exempt from OMB clearance and should be designed, carried out, and reported within two years. Reports would then provide an important basis for ascertaining the direction and focus of the VA's medical care programs.

Although the Veterans Affairs Committees have requested that the Government Accounting Office identify veterans' needs for outpatient care through a survey in 1988, much additional work along these lines must be accomplished to more accurately quantify the health care needs of veterans.

Decentralized Hospital Computer Program

The lack of integration of ADP systems of the VA's departments is a major cause of serious deficiencies in services rendered to veterans. The authors of the Independent Budget do not support any management improvement initiative designed to offset the cost of computer equipment with reductions in medical care personnel. As medical record keeping becomes more complex and systems provide a greater array of information in support of the medical care mission, it becomes essential that the manpower be made available to use and support these systems. Computer-based medical care management systems are essential to the delivery of quality, state-of-the-art medical care and are contemporary tools which a medical care system must use to operate efficiently. Estimated cost $25 million.

Category A Entitlement For Outpatient Care

The FY 1989 Independent Budget presented the rationale for extending outpatient care eligibility to all Category A veterans. It is our opinion that the need for such eligibility is growing rapidly. This is borne out by much anecdotal evidence presented by the VSOs at hearings before the House and Senate Veterans Affairs Committees on September 7 and 9, 1988.

It was clear in those hearings that many specialty clinics had long delays for appointments; delays of four or more months were not unusual. There was also evidence provided that waiting times in the general outpatient clinic areas were frequently an entire day. Access to health care, in such an environment, is perceived to be inadequate or non-existent and many patients leave in frustration and either avoid getting the care needed or seek care outside the VA system.

The fact of inadequate resources available for ambulatory care creates a form of rationing of care to those who can, will, or must tolerate the perceived inefficiencies of the system. Others forego the needed care in the VA. This contributes to a growing perception that care cannot be received in the VA system except on an emergency basis, and access to inpatient care is perceived to be as difficult as obtaining needed outpatient care, since entry to the system is through outpatient.

Category A entitlement for inpatient care was created to provide health care access for needy and otherwise entitled veterans. Access to only inpatient care does not meet the need of the veteran who requires outpatient to stabilize/monitor medical conditions for which inpatient care is unnecessary. Further, since complex care (e.g., certain surgi-clinic procedures such as cataract extractions, lens implants, hemorrhoidectomy, herniorrhaphies, and many plastic surgery procedures) continues to be more acceptable on an outpatient basis, increasing numbers of veterans are being denied access to care for which they had been previously eligible. Whereas Category A veterans are entitled to inpatient care, the amount and level of care available on an inpatient basis is diminishing, especially for the less complex and frequently used surgical and other procedures. Many procedures now are routinely provided on an outpatient basis in the VA system that two years ago were only carried out on an inpatient basis. Limiting eligibility for inpatient care to the Category A veterans becomes a more questionable policy as the modalities of delivery of medical care continue to change.

With such changes occurring in the VA health care system, veterans become confused as to the care for which they may be eligible. It is no longer appropriate to tell veterans they are eligible for inpatient care; rather, they must now be told about the inpatient procedures for which they are eligible. And, confounding the issue further, what may occur on an inpatient basis at one medical center may be performed on an outpatient basis at another medical center. It is time to eliminate the confusion and provide continuity of quality care for eligible veterans that is in their best interest.

It is difficult to estimate the workload impact of this proposal since it would make care available to those who have not been able to use the system for any number of reasons. Consequently, it is necessary to determine the extent of the need and estimates of potential users through purposeful sampling of veterans.

In the absence of such information, a preliminary analysis has indicated that entitlement for all Category A veterans would increase outpatient visits by approximately 750,000 visits and $75 million over expected use in FY 1989 under entitlement mandated in P.L. 100-322. A recent Congressional Budget Office Study showed that the costs associated with this outpatient increase would be offset by a decrease in inpatient hospital costs, resulting in no net cost increase.

In response to the Independent Budget last year, the House and Senate Veterans Affairs Committees requested that the GAO "...conduct a study to estimate the current and potential demand for VA outpatient care of veterans who, under section 610(a)(1) of title 38, United States Code, have entitlement to VA hospital care." This study, if not designed to take into account the issue of shifting care from inpatient to outpatient, will likely underestimate the need for outpatient care. The varying definition of outpatient care is also a problem. In addition, the GAO study does not deal with the need for inpatient care and the care that is not available to veterans on an inpatient basis within the VA system.

We urge the Congress to expand outpatient care entitlement to all Category A veterans based on the same rules that apply to access to inpatient care.

Bed and Staffing Levels

VA Officials frequently refer to the inefficiency that derives from the bed and personnel floors imposed by the Congress. It is important to understand the history. These floors were imposed in the early 1980s at the point when OMB was aggressively pursuing the reduction of the VA system. To stem the reductions in beds and personnel, Congress imposed the floors. We feel that the climate remains the same today as it was in the early 1980s and certainly the VA health care system would appear a likely target for reductions to help address the budget deficit. It is the opinion of the four Congressionally Chartered Veterans Service Organizations preparing this alternative to the President's Budget that the floors for personnel and beds should remain in place to continue to serve the purpose for which they were established.

We recognize that funds must be appropriated to fully meet the costs to support the personnel floor and have argued successfully to achieve this goal. In the medical care budget, Congress has recognized this problem and has asked the VA to more accurately identify, through budget requests, the true requirement for personnel services dollars. Congress is now moving toward meeting the full costs of medical personnel increases anticipated in the fiscal year for which an appropriation is requested.

Medical Center administrators have argued that they could become more efficient if they were not required to support a personnel floor, that in many instances they do not need the personnel level assigned. We submit that in such instances personnel levels be reduced and reassigned to medical centers and programs that do require additional FTEEs or be used to initiate programs such as HBHC, hospice, GEUs, conversion of hospital beds to nursing home beds, etc. Such reassignment of personnel around the system would contribute greatly to expanding the capability of the health care system while containing costs.

Sharing Agreements

Sharing health care facilities and programs between VA and the military medical services is well past the pilot stage. Its remarkable success warrants expansion in whatever long-term planned arrangement may evolve.

Starting with essentially no significant examples in 1975 and following Congressional mandate in 1982, sharing agreements between the VA and the Armed Forces' health care facilities have tripled in the past four years--from 102 agreements in 1984 to 301 in 1988. In fact, every VA hospital with a military counterpart nearby has some sort of sharing program, and joint-use facilities have been built or are in the works in a half-dozen cases.

Although GAO, based on their recent survey, reported an inability to identify specific dollar amounts, it confirmed that the DOD/VA sharing program does indeed save money and improve patient access to care. Other advantages include the elimination of duplicate capabilities, enhanced buying power through combined purchasing, and strengthening the teaching base for intern and residency programs.

While DOD and VA participants enthusiastically give the sharing program high marks, it has its detractors, notably a spokesman from OMB, who candidly admits a bias for privatization, even out of preference for the more costly CHAMPUS/CHAMPVA. Opposition from that quarter can only lend further proof of the program's merits.

In fact, the GAO report, in contrast, supports the cost-saving measure of using CHAMPUS funds to treat military beneficiaries in VA hospitals on a space-available basis when care of VA's beneficiaries would not be adversely affected. Currently, considering the restricted access to medical care for both the clearly entitled veterans as well as those eligible on a space-and-resource-available basis, extending care to non-veterans would be inappropriate.

In principle, however, and as a consideration for future planning, we endorse the GAO recommendation providing there is a reciprocal arrangement for care of veterans and their entitled dependents in military hospitals. The sharing authorized by Congress has further potential only when the level of resource appropriations can be more realistically based upon valid measurement of need.

Prosthetics and Sensory Aids

The timely and appropriate provision of prosthetic appliances and equipment has been a source of chronic concern and frustration to veterans and the VSOs. Clearly, for severely disabled and service connected veterans, prosthetics is not considered a luxury or even an option but, rather, a requirement to maintain a semblance of pre-service quality of life.

As far back as 1981, major organizational and operational deficiencies were evident in Prosthetics and Sensory Aids Service (P&SAS). Working with key DM&S staff, the VSOs were able to effectuate changes in October 1984 that influenced the manner in which P&SAS, as well as all rehabilitative services, functioned.

Unfortunately, and to our dismay, a major flaw continues to exist that chronically precludes P&SAS from successfully fulfilling its mission. Each VAMC with a prosthetic activity receives funds for that service in its general medical care allocation. Because these funds are not earmarked, the temptation to "borrow" or divert funds to other medical center activities is ever-present and commonly practiced, particularly during current general underfunding of DM&S.

As a result of this reprogramming of funds, veterans are being penalized because their needs too often go unmet. It is now a common occurrence that orders for required prosthetic devices are unduly delayed for weeks, months, and sometimes into the next fiscal year. At the end of fiscal year 1987, 5,200 prosthetic orders were backlogged. This number rose to 7,550 at the end of fiscal year 1988, a 45 percent increase in the number of orders that were not filled due to funding deficiencies. Hospitals across the system ran out of money for purchase of prosthetic and orthotic appliances in the third quarter of that fiscal year.

Other causative factors are involved in this phenomenon, including local facility directors' desires concerning which program should be funded and at what level. There is also the fact that prosthetic services and rehabilitation medicine are viewed as losers under the DRG resource allocation model.

A plausible approach to remedy this untenable situation is the institution of centralized funding for the purchase of prosthetic appliances and equipment. Although the concept is not new, we expect opposition to the implementation of such a procedure from regional directors and many medical center directors as another restriction on their management flexibility. It is, however, that very flexibility that causes P&SAS to be so ill served. Implementation of such central control can assure the reduction of the existing backlog of orders as well as assist the Service in delivering the most appropriate devices to disabled veterans.

An associated problem is the result of attrition of professional personnel in the P&SAS of many hospitals, leaving marginal talent to service patients. Similar situations afflict the eight STAMP teams and the five Comprehensive Rehabilitation Centers. They are so underfunded and understaffed that they have yet to be fully activated.

P&SAS has long been a source of concern to the VSOs, as it is a highly visible part of the medical center environment charged to serve the needs of the most severely disabled veteran, typically with the highest priority of entitlement to care. The current state of the service is indeed unconscionable, despite the many efforts put forward by the Director and his Central Office staff who remain committed to making the program work.

We are requesting an additional 50 FTEEs and $4 million to cover salaries for increased staffing and to augment funds for purchase of prosthetic equipment and supplies.

The entire P&SAS budget be line itemed and controlled through centralized allocation

P.L. 100-690 the "Anti-Substance Act of 1988" provided a three year authorization for substance abuse treatment for veterans. This is an amount in addition to that which is currently in the budget of the Veterans Administration. This is a major policy initiative of the Administration and the Administration calls for the maintenance of VA substance abuse programs.

In keeping with the importance of the substance abuse program to veterans we support an appropriation up to the authorized level-cost of $15 million.

THE FUTURE

The Veterans Service Organizations' Independent Budget deals primarily with accounts for which the Veterans Administration's appropriation are required, accounts that have a direct effect on veterans' benefits. The veterans' health care system, however, is one benefit also indirectly influenced by federal budget provisions that involve programs in the private health care sector.

A recent study by the American Health Planning Association, Veterans Health Care: Actions and Interactions (January 1987), clearly demonstrated interdependencies among the pluralistic public and private health care systems. Numerous examples were provided of how changes in one component of the health care system can affect other components of health care as well as those outside health care. One fundamental conclusion of the study was that as cutbacks continue in Medicare and Medicaid, and as more flexibility is given states in their conduct of Medicaid programs, the VA becomes the provider of last resort for those who do not have resources to meet increasing copayments or the premiums of supplemental insurance; those who had been eligible under Medicaid find they cannot meet the increasingly stringent criteria. The study underscored the very real prospect that veterans at the lower end of the economic scale, being buffeted among the many federally funded health care programs, would be rejected through underfunding of some programs unable to qualify for others, and ultimately would lose all access to care.

Because the VA is so manifestly an integral part of the nation's health care industry, these VSO authors have a very real concern regarding the alarming trends compromising the access to and quality of care in the private medical sector, the impact of those trends on the VA system, and their implications for the future.

Perhaps the most telling description of the adverse effects of current legislation, regulations, and resource cutbacks in federal programs on health care services has been provided by the National Committee for Quality Health Care, which commissioned a 1988 study called *Critical Condition--America's Health Care in Jeopardy*. Interestingly, some of the authors of that publication recently held executive federal government positions responsible for the implementation of federal health policy. It is an excellent report that should contribute much to the continuing dialogue in search of proper priorities and a more comprehensive national health policy. *Critical Condition* offers several sobering conclusions about our future health care delivery system:

> There will be an increase in the number of hospital closings and the number of hospitals closing unprofitable units. Those most at risk are hospitals most important in providing basic health care services. An estimated 40 percent of all hospitals will be closed or converted to other purposes by the year 2000. The amount of charity and bad debt care public hospitals provide is increasing. Closure of public hospitals would also increase the pressure on other hospitals in the community to provide uncompensated care, which they may not be able to afford.
>
> The number of uninsured Americans is growing. Almost 18 percent of Americans have no health insurance. The proportion of poor Americans covered by Medicaid is declining from 65 percent in 1976 to only 38 percent in 1984.
>
> Patients will be forced to shoulder a growing percentage of their health care bills. There will be a growing demand for charity care among both the uninsured and insured, while hospitals will be less able to meet this demand due to lower operating surpluses.
>
> Our current payment system may be unable to differentiate between excess supply and needed services and, consequently, may adversely affect availability and access to health care.
>
> Increases in the costs of providing care to Medicare patients have increased faster than payments.
>
> Access to physicians may become more difficult in the future as payment practices fail to cover costs while malpractice premiums and regulatory controls over physicians rise.
>
> The supply of nurses is falling far behind demand. Low salaries are contributing to nursing shortages. Today's constraints on hospitals' finances make salary increases more difficult.
>
> The supply of nursing home services has not kept up with demands. To meet the demand, one 120-bed nursing home per day would have to be built over the next five years.
>
> And finally, if we are to avert the trends described in this report, we must develop health policy assuring adequate access to health care for all our citizens; this requires adequate funding for all our providers.

Since publication of this report, those trends have gained momentum. The VA is now candidly admitting to the rationing of veterans medical care due to understaffing and underfunding.

Lacking corrective action to counter these unwavering trends, there can only be a continued loss of health care access for increasing numbers and a growing inadequacy of funding for all health care providers. Given that outcome, it would be even more difficult for an already constricted VA system to continue serving as even an inadequate safety net for veterans unable to afford or to obtain outside medical care. This safety net would disappear completely if there were continued concomitant underfunding for and reduction of access to the VA health care system. Nor could the private medical sector continue to provide contract options to assist the VA in fulfilling its burgeoning long-term care responsibilities to the ever-increasing numbers of eligible aging veterans.

We share in the growing consensus that the time has arrived to definitively address options for a fundamental structural reform in the financing and delivery of health care in this country. It is this alarming and compelling prospect that takes us beyond the pending FY 1990 Veterans Administration budget into a speculative look at the future.

The nation's medical literature is filled with analyses of the shortfalls in the provision of health care and discussions of the many options that may next be pursued in Congress. Most authorities underscore their concern that nothing less than a complete reordering of the nation's health systems and programs will do. Robert Dickman expresses that sentiment very well: "We cannot continue this patchwork approach to health policy. If we have learned anything at all from history, it is that tinkering--especially multi-billion tinkering--inevitably creates new problems. It is time to address the major unitary alternatives--the varieties of national health insurance and national health service--and to debate their relative merits." It is our belief that the VA health care system is a national resource whose future must also be considered in the context of that debate.

If the past is prologue, health care futurists must never forget what led to the present turmoil:

Congress, in passing the National Health Planning and Resources Development Act (P.L. 93-641) of 1974, established a principle tenet of what could have evolved into a National Health Policy with true moral affirmation. That legislation, long since abandoned, embraced the goal of "equal access to quality health care at reasonable cost for all Americans." It was not then foreseen how subsequent piecemeal legislative tinkering would so dramatically disrupt the integrity of the nation's voluntary, pluralistic public-private health care system. The well known adage applied to the physician, "first, do no harm," today needs to be equally applied to the health care economist.

Since that 1974 legislation, policymakers have launched various programs aimed mainly at containing costs. They have given little attention to systematic factors, such as demographic trends, or health care practices, such as the expanding technology and personnel utilization, that increase costs. Even less concern seems to have been given to the practical meaning of social justice and the proper role of government in the health field. In 1975, the block grants concept was initiated and has since reappeared in today's "new Federalism" regardless of the inequity in the different states' ability to provide. During the Carter years, attempts to legislate regulatory approaches to health care cost containment were aborted and the health providers' "voluntary effort" subsequently failed. In 1979, health care was declared to be a business not subject to such "restraint in trade" as health professional societies' established ethical guidelines with respect to advertising. Thus, many of the causative factors of turmoil in the nation's health care scene antedated the Reagan years. Perhaps none, however, has exerted such influence as the "competitive medical market"--the companion piece of supply-side economics expounded in the Gephardt-Stockman legislation proposed in the late 1970s. There has since followed one of the most extravagant and disruptive demonstration projects in history: the test of efficacy of "free-market" health care resting uneasily on the shifting base of a Medicare payment system whose resource pool is constantly changing and whose legislative and regulatory shape is in a state of constant flux.

Competition was touted as a means of reducing regulation. It has not done so. In fact, most of the changes that have occurred during this decade have been the result of regulation: the Prospective Payment System, Diagnosis Related Groups, Professional Standards Review Organizations, price caps, and criteria for utilization controls. Competition was expected to reduce costs, yet the national health expenditure of $248 billion in 1980 has risen to well over $500 billion in 1988. Competition has given birth to such new expenditures as advertising and marketing, the duplicate acquisition of high-cost technology, and burgeoning administrative recordkeeping. Competition has certainly discouraged cost shifts, for no one competes for the provision of medical care to the poor. The incidence of uncompensated care, the volume of unmet medical need, and the numbers of uninsured have all spiralled upward. Those numbers include individuals who in previous times would have had access to health care in the federal sector health care delivery systems.

Many are now wondering whether the treatment to cure skyrocketing health care costs--competition--is worse than the disease that spawned it.

In no case is competition in the medical arena going to completely disappear, nor is the preoccupation with health care finances. The purpose of competition, however, must not be to reduce health care expenditures by denying care to those who cannot pay the price. Its goal must be a more modest one: to induce providers to consider price and thus to stimulate and reward efficiency. Modern medical technology is frightfully expensive and so is the cost of developing it, but it is the price to be paid for life-saving capacities and increased longevity. But surely this preoccupation with the monetization of medical care must be tempered by some ethical concerns. With the transformation of health care from a humanitarian service to a business endeavor, the laws of economics have become the controlling influence in health policy, if indeed there is any policy. Qualities such as wisdom, compassion, human concern, and social responsibility do not translate into economic values.

It is to be hoped that in the pursuit of cost containment options for tomorrow, health policymakers do not resort to indiscriminate rationing of health care. The theme of the newly launched "generational equity" organization calls for rationing of medical care for the elderly. It is receiving growing attention from the media with the picture of a burdensome older population. Once we admit that rationing of care is proper, we put ourselves at risk. Because of varying affluence among the elderly, a means test applied to Medicare would be far more desirable and equitable than rationing. Based on the individual's financial means, variable premiums and copayments could be assigned. In fact, Congress just took a step in that direction with the catastrophic health insurance bill. Uwe Reinhardt, in his very interesting proposal for a federal fail-safe health insurance program, recommends that it be financed on one's ability to pay.

The very existence now of a congressionally mandated U.S. Bipartisan Commission on Comprehensive Health Care is a source of encouragement and a sign that something more than continued tinkering is in the offering. The Commission's charge is to "recommend plans to provide long-term care to all seniors and people with disabilities and with assuring access to health care for all Americans." The language comes close to the erstwhile promise of "equal access to quality health care at reasonable cost."

Whether it be mandatory employer-based national health insurance, long-term care coverage through Medicare, a buy-in to Medicaid, or a national health service, the merits of various options under consideration for the reordering of health care systems is beyond the scope of this paper. What the VSOs do wish to affirm is the absolute requirement that consideration of the future integrity of the VA health care system be included in the agenda of any congressional debate on the realignment of the nation's health care services.

It is from this perspective that we offer the following recommendations for the record:

o That pursuit of fundamental structural reform of the nation's pluralistic--public, private and federal--health care systems be given the highest priority by the Congress and the nation's health policymakers.

o That "means testing" be applied to all federal health care subsidy programs.

o That federal budget balancing not be sought by further restrictions on appropriations in support of federal health care programs.

o That the current need be eliminated for use of the VA health care system as a patient safety net by mending the cracks in the private and public systems, and that those veterans in Category A be fully identified and a full continuum of VA care be provided them in accordance with their need.

MEDICAL AND PROSTHETIC RESEARCH

The appropriation for Medical and Prosthetic Research supports the three categories of VA health research: medical research, rehabilitation research, and health services research.

Medical research is centered on problems of particular importance to veterans, and most VA researchers are VA clinicians. Thus, the VA's medical research has a clinical orientation and a high relevance to needs of VA patients. Rehabilitation research might be regarded as a specific example of this thrust of VA research to meet needs especially important to veterans. Rehabilitation research is directed at the needs of functionally impaired veterans; it attempts to bring engineering and computer technologies, among others, to bear in developing new devices and techniques for overcoming these veterans' impairments and for maximizing their functional abilities and independence. Health services research is directed at improving the effectiveness and efficiency of the VA health care delivery system.

Historically, VA research constitutes one of the proudest chapters in the history of the Veterans Administration. The value of contributions to medical knowledge by VA researchers far exceeds the cost of research, not only in terms of dollars, but also in terms of lives extended and quality enhanced. The prolific yield from VA research has served the health care needs of veterans and benefited the population as a whole. Furthermore, that research effort is an essential component in the VA's academic commitment in conjunction with it's affiliated medical schools and a strong inducement for VA recruitment and retention of high caliber professional staff. The output of physicians and scientists trained in medical research through the VA's Career Development Program is a national resource, 37 percent having remained in VA careers and 20 percent in university settings.

THE CHALLENGE

Health care is a rapidly changing field and we note with concern the fact that only two percent or less of the VA's annual budgets have gone to research while, in other high tech and rapidly changing industries, the percentage typically is much higher.

Decline of the VA research programs will lower staff quality and morale and ultimately VA graduate medical education, a sustaining element in the quality of patient medical care. The years of absorption of pay raise, underfunding for inflation, and penalty decrements for productivity have eroded the resource base for VA research in a manner not unlike that for medical care. However, that does not tell the whole story. For the past five years, funding levels have had no consistency due to episodic arbitrary cuts by OMB. Even though Congress each year has appropriated fractional amounts more than the administration requested, the fluctuation in both resources and personnel have been dramatic and particularly disruptive of the consistency needed for stable research programming.

Most research projects require multiple years for completion and are funded with commitments for three years or longer. High performing research teams need stability. Erratic funding thus impairs research to a greater extent than might be thought from a simple examination of the percentage level of fluctuations.

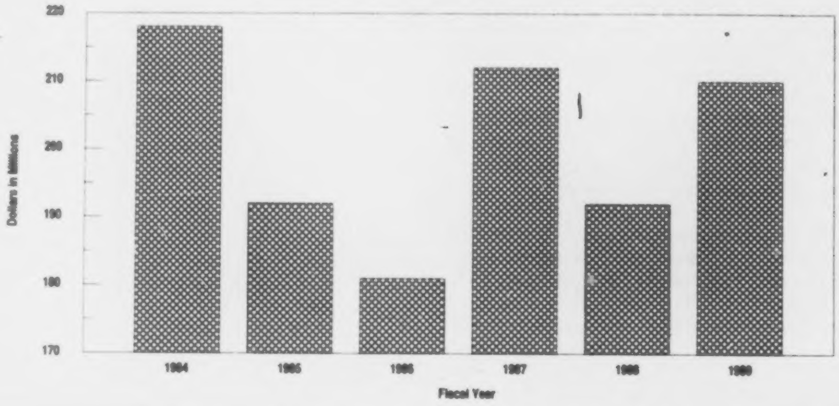
Table 10 illustrates this problem. It will also be noted that the FY 1984 appropriation was greater than that received in FY 1989, when inflated dollars have reduced purchasing power. Similarly, the 1989 employment is lower than the 1984 level (Chart 11).

TABLE 10
AVERAGE EMPLOYMENT

FY 84	4,600
FY 85	4,551
FY 86	4,401
FY 87	4,272
FY 88	4,537
FY 89	4,407

The FY 1989 Independent Budget, in consideration of budget austerity, called for no increment for research beyond the increase for coverage of uncontrollable expenses, the so-called "current

Chart 11
Medical and Prosthetic Research Budget
FY 1984 - 1989



services." When calculation for current services in VA research starts with the previous year's appropriation, it builds on an eroded resource base and, in this case particularly, does not permit recovery from the severe reductions sustained between 1985 and 1988.

Paradoxically, the VA Research Office is receiving increasing numbers of excellent merit-approved proposals while progressively loosing the capacity for funding them. In FY 1984, of the 1119 research proposals passing merit review, 61 percent were funded. By FY 1988, the funding percentage fell to 40 percent and the expectation in FY 1989 is that only one third of the approved projects will be funded (Table 11).

TABLE 11
MERIT REVIEW PROPOSALS

FY	Merited	Funded	Percent
84	1,119	683	61
85	1,064	628	59
86	1,270	670	53
87	1,228	660	54
88	1,297	581	40
89	1,400	490	35

One can anticipate that as the chance diminishes for a meritorious proposal being funded, the disincentive for a prospective grantee to submit a proposal increases.

THE STRATEGY

Considering the size of the DM&S budget, economizing in that two percent portion which focuses on the search for better methods of serving veterans health care needs seems ill founded. Rehabilitation research and health services research most clearly fall into this category. Rehabilitative research is unlikely to be carried out elsewhere, and thus restrictive funding will work to the disadvantage of large number of veterans with disabilities, many of them service connected.

o The VSOs strive to reestablish and maintain a balanced consistent resource capability for research funding at levels that will take full advantage of the numbers of high quality research proposals available for funding.

o Further, funding must be provided to pay the cost of evaluating the products from rehabilitation research so that the new technology can be released for industrial production and be made available to those in need.

SPECIFIC RECOMMENDATIONS

The VSO authors recommend the appropriation of a resource level that will restore vitality to the VA research activity. Opportunities for research pursuit of answers to medical conundrums have never been greater, especially in the field of molecular biomedicine.

It is our belief that $25 million is needed to cover uncontrollable costs and reestablish current services. (See Tables 12 and 13). Medical research funds are based on the more valid FY 1985 resource base. In addition, $14 million is requested for enhancing investment in high priority, ongoing programs.

MEDICAL RESEARCH

This level of funding will restore the VA's ability to fund a higher percentage of the meritorious proposals received. For the past 3 years, variable levels of funding have been transferred to the VA from DOD's research budget. Multiyear grants have been funded from this resource. Anticipating that a FY 1990 transfer of such funds may not be continued, we are requesting a $5 million increment to the FY 1990 budget to cover future year commitments that derive from the DOD-based research projects.

We are also requesting an increase of 50 FTEE and $2.2 million to restore the level of participants in the Individual Research Career Development program because of the training program extension of individual fellowships from 3 to 4 years.

The increase will help to expand such directed priority research as:

Schizophrenia, Gerontology/Geriatrics, Spinal Cord Regeneration, and AID..$1.3M
Establish a Center for Schizophrenia Research and a Center for Neurobiomedical Research...$1.0M

REHABILITATIVE RESEARCH

The recommendation for enhanced funding of Rehabilitation Research takes into consideration two concerns: the replacement of a sizeable budget cut from FY 1988 to FY 1989 and the additional resource need for delayed evaluation of several research products--prior to their release for industrial output.

Notable among such products are the robotic arm, the Functional Electronic Stimulator (FES) units, and the Unistick Vehicle, for which millions of research dollars have already been invested. A budget increment of $4.7 million is a conservative estimate to cover such evaluation requirements.

TABLE 12
MEDICAL AND PROSTHETIC RESEARCH RECOMMENDED INCREASES

	FY 1989 Actual Dollars in millions	FY 90 IB Recommended Appropriation in Dollars in millions	Program Enhancements* Dollars in millions
Medical	$179.1	212.3	(9.5)
Rehabilitation	19.0	27.1	(4.7)
HSR&D	9.4	9.8	--
Agent Orange	2.7	--	--
Total	210.2	249.2	(14.2)

*Included in FY 1990 Independent Budget recommended appropriation.

TABLE 13
MEDICAL AND PROSTHETIC RESEARCH
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

FY 1989	APPROPRIATION	210,240
FY 1989	Supplemental Funds	14,460
FY 1989	Current Services Level+	224,700
FY 1990	Payroll-related Increases	
	Federal Empl. Retirement System	800
	Annualization of 1989 Pay Raise	1,300
	Annualization of 1989 FEHB	200
	Pay Raise - 1990	4,000
	Health Benefits - 1990	800
	Inflation	3,200
FY 1990	Current Services Level+	235,000
FY 1990	Medical Research Increase	4,500
	Rehab Research Increase	4,700
	DOD Annualization*	5,000
FY 1990	IB RECOMMENDED APPROPRIATION	249,200

+Funds necessary to maintain medical research services at the FY 1985 level and all others at 1988 level.
*Represents transfer or annualization of funds.

HEALTH SERVICES RESEARCH

We make no specific recommendation for funding beyond current services except to observe that study is needed to explore possible realignments of VA health care facilities and programs if continued understaffing and underfunding should occur.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation supports the Washington, D.C. Central Office staff of the VA health care system, as well as a health professions scholarship program for students in nursing and certain other health professions.

THE CHALLENGE

DM&S Central Office has a multiplicity of issues with which to deal. There has perhaps never been a time when management of the VA health care system has been faced with greater odds. We would identify at least three issues presenting the greatest challenge:

1. The need for quality control of veterans health care.

2. Attention to human resources for staff personnel.

3. The imperative of enhanced strategic planing.

The need to maintain access to quality health care for all entitled veterans in an environment of chronic personnel shortages and restricted resources is clearly the top priority issue. Agency response to the Congressional mandate for development of an improved quality assessment capability is already underway. The avoidance of rationing medical care, however, is dependent upon a needs--based adequacy of budget appropriations.

Staff shortages of nurses and allied health professions are already critical, and physician shortfalls are threatened. DM&S has made a commendable start on the development of a more comprehensive human resources program with the creation of a new Recruitment and Retention Office in VACO with responsibility to pursue a number of initiatives covering work environment, benefit packages, education and career development opportunities, as well as flexible salary scales.

It seems ironic, at a time when operational innovations are needed to accommodate resource shortfalls and realignment of the system is required for handling the full impact of aging veterans, that commitment to and investment in strategic planning has been curtailed. The VA system has always been interdependent with the private medical sector and with academia. Profound changes are occurring there, the ultimate outcome of which may have significant impact on the VA medical system. The latter should be ready with plans and options to adjust to various structural reforms likely to involve the nation's health care systems.

Personnel cuts in MAMOE have reduced DM&S Central Office staffing by almost one-third relative to levels five years ago. This staff must manage the headquarters of an organization that spends well over $10 billion a year, and has some 200,000 employees who deliver a complex and vital service at over 200 major delivery sites. This central staff also devotes a substantial portion of its attention responding to Congressional inquiries and Executive Branch direction. The need for adequate management staff is particularly acute in the current era of tight budgets and it is especially important to avoid waste and inefficiency due to inadequate management supervision.

In the past, the Independent Budget has recommended that a management consultant be employed to conduct a desk audit of the DM&S Central Office to determine whether the current austere staffing was commensurate with assigned program responsibilities. To our knowledge, this has not been done. Although we have no basis for identifying a realistic MAMOE FTEE requirement, we have a real concern that recent manpower cuts have been excessive.

OUR POLICY

DM&S Central Office has managed to function with the current staff level, and given the economies in federal government spending necessary to meet current deficit reduction targets--(economies in which the VA must share), we can only recommend continuation of the current staffing level.

The VA's commitment to quality of care and the need to remain competitive with the private sector in the human resources markets makes it necessary for the VA to implement a comprehensive human resources program. Hopefully, this will allow the VA to recruit and maintain professional proficiency in its health manpower pool.

Finally, it is our conviction that the sizeable investment in the MEDIPP process should not be curtailed.

SPECIFIC RECOMMENDATIONS

CURRENT SERVICES

Provide supplemental funds of $1 million in FY 1989 and an additional $2 million in FY 1990 to maintain current services. As Table 14 shows, the enacted appropriation for Medical Administration and Miscellaneous Operating Expenses (MAMOE) for FY 1989 is $48 million. However, maintaining the FY 1989 staffing at the FY 1988 level will require supplemental appropriations of approximately $1 million, mostly to cover the federal employees' pay increase that went into effect on January 1, 1989. Thus, the FY 1989 current services level is $48.9 million. Given the reduced staff level in the central office, it is particularly important to fully fund the $1 million increase that is needed to maintain services at the FY 1988 level.

For FY 1990, the current services level is $50.9 million. Additions of $2 million over the FY 1989 level are required in FY 1990 for payroll-related items, primarily for the expected 4 percent pay increase effective January 1, 1990, and $.7 million is required to cover inflation in non-personnel costs. Again, fully funding these cost increases is particularly urgent to forestall cuts in central office staff.

EDUCATION AND TRAINING

AIDS Related Training–cost $3 million

Reestablish Health Manpower Training Grant Program–cost $5 million

Authorize Associate Degree Training Program–cost $8.4 million

For details and cost estimates on the above three recommendations see Medical Care, Strengthening Medical Care, and Human Resources Program pages 82 and 83.

In total, the recommended funding level is $53.9 million for FY 1990 excluding amounts for proposed legislation.

TABLE 14
MEDICAL ADMINISTRATION
AND
MISCELLANEOUS OPERATING EXPENSES
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

FY 1989	APPROPRIATION	47,900
FY 1989	Supplemental Funds	
	Pay Raise	900
	Federal Empl. Health Benefits	100
FY 1989	Current Services Level*	48,900
FY 1990	Payroll Related Increases	
	Federal Employees Retirement System	100
	Annualization of 1989 Pay Raise	300
	Annualization of 1989 FEHB	40
	Pay Raise - 1990	900
	Inflation	700
FY 1990	Current Services Level*	50,940
	AIDS Related Training	3,000
FY 1990	IB RECOMMENDED APPROPRIATION	53,940

*Funds necessary to maintain services at the FY 1988 level.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

This appropriation provides grants to assist states in acquiring or constructing state homes that furnish domiciliary and nursing home care to veterans. It also provides grants that assist in the expansion, remodeling, or alteration of existing facilities of this type, including hospital facilities of state homes. Grants may not exceed 65 percent of the total cost of a project.

As described in the discussion of our extended care initiative (in the section on the Medical Care appropriation), expansion of state homes is one important potential source of the rapidly increasing nursing home capacity the VA needs. However, the willingness of states to expand state homes or build new ones is limited, since states must pay most of the cost of caring for veterans in these homes. In recent years, states have been willing to undertake less expansion of this capacity than the VA would have liked.

For FY 1990, we recommend an appropriation of $42 million for these grants, which is the current services level--that is, the same as the appropriation for FY 1988. We expect this will fund a substantial expansion in the state home program.

GRANTS TO THE REPUBLIC OF THE PHILLIPINES

These grants assist in the replacement and upgrading of equipment at the Veterans Memorial Medical Center in the Phillipines and in rehabilitating the physical plant and facilities of the Center. The Center provides care to U.S. veterans. It is now over 30 years old, so replacement and rehabilitation are major needs. We recommend the usual annual grant of $500,000.

CONSTRUCTION PROGRAMS

CONSTRUCTION PROGRAM

PRINCIPLES AND GUIDELINES

The Independent Budget recommendation for construction programs is based on a carefully developed set of 12 principles and guidelines, as follows:

1. Construction funding should ensure the integrity of the VA physical plant. There must be no covert downsizing achieved by allowing the physical plant to deteriorate.

2. Veterans Administration facilities must be available where veterans need them. This may require major expansions or new facilities in areas of rapid veteran population growth. Conversely, the contraction of facilities in areas of declining need or resulting from a change in mission also is appropriate.

3. The highest priority in construction funding should be given to projects necessary to meet modern safety standards. These include seismic protection, asbestos hazard abatement, and correction of fire and safety deficiencies.

4. VA facilities must be brought up to current privacy standards and should routinely meet all other requirements mandated by law or by accreditation criteria.

5. The VA physical plant must be made adequate to meet the needs of the current, rapidly aging, veteran population. Specifically, the VA health care system must have sufficient treatment capacity to meet these needs and must adapt existing space and services configurations to the changing patterns of care required by current veterans. This implies the large-scale conversion of unused hospital beds to nursing home use and to other alternative uses to support the medical care mission.

6. As a matter of principle, the primary responsibility for nursing home care of the Nation's veteran population rests with the federal government, and is not the responsibility, predominantly, of the states. The obligation of the veteran during military service was to the federal entity; a converse obligation to the veteran is now held to exist.

7. The selection of construction projects should be based on an adequate system-wide process for the establishment of priorities. A process for the rational establishment of national and regional priorities should consider the full range of Veterans Administration needs. We hold that such a process does not now exist in institutional form. We hold it to be essential that the medical districts provide detailed input to any national planning effort.

8. The VA should improve the cost efficiency of its current design criteria and facility planning process. Excess dollars spent on a construction project are dollars not available for other purposes.

9. Both maintenance and construction funding should be explicitly directed to effectively take advantage of improvements in medical technology.

10. As a principle basis for construction planning, the VA must promptly develop an inventory of current space, function, and technical deficiencies, including information on their severity.

11. Sufficient funds must be made available in the advance planning and design fund to prevent delays in the construction needed to meet VA goals.

12. There should be a National Cemetery with available grave space, not limited to cremations only, in every state, and National Cemeteries with available grave space located within reasonable distance of major population centers. Currently, priority should be given to the largest population concentrations in those states with no open cemeteries.

CONSTRUCTION PROGRAM

OVERVIEW

Two appropriations fund the bulk of the VA's construction activities: Major construction provides funds for projects costing more than $2 million; minor construction pays for smaller projects and also for the staff necessary to the planning and supervision of construction activities. In addition, a small third appropriation currently supports the Parking Garage Revolving Fund. Most funds in the construction appropriations are dedicated to health care projects.

THE CHALLENGE

Needs should form the basis for the determination of funding required for construction. Construction needs should be formulated based upon a formally institutionalized process that is designed to provide a rational analysis of construction requirements derived from a nationwide assessment of such requirements. However, the VA has failed to propose either a formal and institutionalized analytical process for the determination of nationwide priorities, or a formal inventory of needs assessments made at the treatment facility level. A rational process designed to project construction requirements in priority would require a knowledge of:

o Maintenance and repair needs of existing structures, systems (electrical, heating, plumbing, etc.), and equipment used by the individual medical center;

o Shortfalls in existing space, systems, and equipment needed for the current activities of the individual medical centers; and

o Shortfalls in the space, systems, and equipment that will be required by future medical center operations, as these future operations are envisaged in approved MEDIPP plans and designed to meet the changing nature and location of the current veteran population. (Also see discussion of MEDIPP on page 83).

The Facility Development Planning (FDP) Program, initiated in FY 1987, is the method selected by the agency to identify current and projected facility needs of individual medical centers. However, our independent assessment of the FDP Pilot Program indicates that these goals have not been achieved and the process has proven excessive in both cost and time. The agency's original estimate for full implementation of the FDP program was $40 million, an average cost of $250,000 for each medical center with a six-month time schedule. Although the agency has withheld detailed information on the pilot program, our investigations indicate that costs for at least two of the projects exceded 100 percent of original estimates. In addition, all four pilot projects have been under development for more than a year. In fact, as of January 1, 1989, none of the pilot projects has yet been totally completed. This evidence suggests that initial direct costs to implement the FDP Program systemwide could approach $80-$100 million, not including the cost of VA personnel and support.

We recommend that the FDP Program be delayed until a more efficient and cost-effective process has been developed and that a greatly simplified system to provide basic facility data be quickly developed, independent of a facility master plan.. This system would provide a systemwide profile of VA medical center needs for resource allocation and signficantly reduce the cost and time required to develop individual FDPs, and immediate action is necessary to prevent further irreversable expenditures on this program. Further, we hold that the MEDIPP process remains essential to any national planning effort in that it provides a concept of construction funding priorities as envisioned by the several Medical Districts. We would therefore urge that the current MEDIPP process continue to be funded.

When a revised FDP process is fully functional, with procedures implemented to ensure useful and current data, the VA will then possess an inventory of current facility needs. Such an inventory also will support a more rational process within the several medical districts in the preparation of their annual MEDIPP projections. It remains, however, that neither process, alone or in combination, will be sufficient to permit the VA to establish a set of nationwide funding priorities for construction that will meet the current and future needs of the veteran population. The data provided by the FDP and the MEDIPP will form the base for planning, but it will be necessary to create a formal institutional process that will permit the VA to formulate a nationwide construction strategy. This will help justify VA funding objectives to the Administration and the Congress and will permit the rational allocation of such construction funds.

The absence of a sound basis for the establishment of construction priorities at the national level is but one of the major deficiencies in the VA construction process that have been identified by studies the VA itself has commissioned. Other major deficiencies include:

o Excessive time required for construction projects, being typically 10 years from conception to completion for major construction.

o Costs that are sometimes excessive.

o The inability of the VA to deal systematically with problems that arise in the construction process.

Appendix D: "Problems in the VA Construction Process," describes the major findings of these studies and provides more detail concerning these challenges.

THE STRATEGY

Our most urgent construction program concern, then, is for the VA to develop a facility planning and design process that works well, and specifically one that:

o Completes projects more rapidly; five years from the conception to completion of major construction projects is held to be an appropriate goal.

o Chooses projects based upon a rational assessment of requirements nationwide and on a sound system for setting priorities among those requirements.

o Provides projects that meet medical centers' needs well, whether current or future.

o Is economical.

o Catches problems quickly, before they become severe, through an effective system of standards and indicators for monitoring ongoing performance along such dimensions as quality, timeliness, and cost.

An immediate task for the agency in meeting these goals is to complete the development of a sound Facility Development Planning process. Successful completion of the pilot test program for the FDP, involving four VA medical centers, remains a prerequisite to the implementation of this process system-wide. Once a proper FDP process has been established, the foundations necessary to the development of a needs-based construction budget will be in place.

Neither we nor the VA know what the true construction needs of the VA are. However, projected against a rationally devised assessment of nationwide requirements, with priorities established to meet changing conditions, technologies, and demographics, we can acknowledge an immense shortfall in construction maintenance, upgrade, and replacement based upon our own data sources. Accordingly, we have recommended a total construction appropriation for FY 1990 in the amount of approximately $922 million. This amount incorporates all of the major construction needs projected for FY 1990 by the VA in its current Five-Year Medical Facility Development Plan. Within our total projections, we have also allocated a significantly increased sum for minor construction in recognition of what we hold to be a wholly unacceptable and rapidly accelerating deterioration of the current physical plant, a process now well underway. We hold that our projections for FY 1990 are hardly excessive, noting for example that the VA is now contracting for only two hospital replacements, or top-to-bottom renovations, annually. At this rate, the VA is operating on an 86-year replacement cycle for its 172 hospitals. We believe such a lengthy apparent replacement cycle is wholly unacceptable.

The FY 1990 IB also reflects the reestablishment of a reasonable strategy for locating cemeteries in the National Cemetery System. At OMB's insistence, the VA has for years maintained that the system need have no more than one National

Cemetery, with available burial space, in each of the ten federal regions. In too many cases, this means extremely long travel distances for the widows and children of veterans honored by burial in a National Cemetery. Realistically, it deprives many veterans of [illegible] option of burial in a National Cemetery.

The VSO authors of this budget are unanimous in agreeing that a true National Cemetery System that actually offers veterans what it has appeared to promise must meet two criteria:

- o The National Cemetery System must provide at minimum a National Cemetery with available grave space in every state. Eight states do not now have open National Cemeteries.
- o There must be a National Cemetery with available grave space within reasonable distance of each of the nation's major veteran population centers.

The FY 1990 IB has been designed to assist the National Cemetery System to begin to meet these criteria.

SPECIFIC RECOMMENDATIONS

The specific recommendations for construction programs, as in other program areas, in the FY 1990 IB are based upon our concept of the strategy necessary to meet the challenges in this program area.

MAJOR CONSTRUCTION

We recommend that $635 million be appropriated for major construction in FY 1990. Our source for funding needs projections for FY 1990 has been the VA's current Five-Year Medical Facility Development Plan. While we recognize that the specific projects to which these funds are dedicated may not meet the priorities that might be developed in an in-depth analysis of national requirements, we also recognize that to achieve less in FY 1990 would be catastrophic in view of the current replacement cycle, changing clinical requirements, and the age of current plants.

Within the $635 million total, we have continued our recommendation for the allocation of $40 million to the advance planning fund and the design fund, as shown at Table 15. It is intended that these funds permit projects to move more expeditiously through the planning and design stages of the construction process. As such, they are intended to deal with one of the major problems that has excessively delayed VA projects in the past. The $40 million recommended substantially exceeds the amount allocated to these purposes in the past. In funding them generously, the FY 1990 IB seeks to accelerate the construction process. More importantly, the FY 1990 IB seeks to ensure a large dollar volume of projects in the pipeline. Underfunding in this area chokes off projects by constricting the front-end planning and design stages. A strategy of strong support for planning and design will permit rapid expansion of the overall volume of necessary major construction projects once the VA's process for priority

TABLE 15
CONSTRUCTION PROGRAMS
(dollars in thousands)

CONSTRUCTION CATEGORY	1987 APPROP.	1989 APPROP.	1990 RECOMM. APPROP.
MAJOR CONSTRUCTION			
Medical			558,920
Advance Planning Fund And Design Fund			40,000
Nursing Homes			30,000
Cemeteries			6,000
TOTAL MAJOR	403,000	363,040	634,920
MINOR CONSTRUCTION			
Medical			200,000
General			[160000]
Conversions			[40000]
Regional Offices			5,000
National Cemetery Program			10,000
Staff Offices and Admin.			60,000
TOTAL MINOR	116,000	111,600	275,000
PARKING GARAGE REVOLVING FUND	3,900	26,000	12,000
TOTAL CONSTRUCTION APPROPRIATION	522,900	500,640	921,920

setting has been rationalized.

The FY 1990 IB has designated $30 million for the construction of new VA nursing homes. This amount will permit the funding of 4 new nursing homes of 120 beds each. Aging of the veteran population will require this rate of addition of new VA nursing homes throughout the 1990s. We hold that this rate of nursing home construction will exist independently of VA compliance with our recommendation, which the FY 1990 IB also funds, to convert 1000 existing hospital beds to nursing home use annually through the 1990s, with a one-time conversion of approximately 2000 such beds to this purpose in FY 1990.

Finally, our recommendations for the major construction appropriation include $6 million for the acquisition of land for new National Cemeteries in states that currently have none. The VSOs recommend the addition of two new national cemeteries annually until the National Cemetery System has met the VSO goals already articulated.

The remaining approximately $559 million of the major construction appropriation should be devoted to those other medical construction requirements, all of which we hold valid, which have been identified for FY 1990 by the current Five-Year Medical Facility Development Program.

MINOR CONSTRUCTION

The FY 90 IB recommends an appropriation of $275 million for FY 1990. The minor construction fund pay for smaller projects devoted mostly to keeping VA facilities in repair and, within dollar constraints, up-to-date. As shown at Table 15 the IB recommendation for FY 1990 significantly exceeds the appropriation for FY 1989. As such, it represents the urgent and growing concern of the VSOs for the updating and repair of existing VA facilities. The largest number of VA facilities date from the 1950s. They are at an age now where the need for updating and repair is high and growing. Earlier appropriations have fallen far short of meeting this need.

Most of the projected minor construction funds, the sum of $200 million, has been identified for medical construction. Of this amount, the FY 1990 IB recommends that $40 million be set aside for the conversion of existing medical center space to nursing home use, to be made available for this purpose only. It is estimated that $40 million should be sufficient to permit the conversion of 2,000 bed spaces to this purpose in this fiscal year, and reflects the concern of the VSOs that the 1,000 bed conversion recommended in the FY 1989 IB was not accomplished. The VSO analysis of nursing home needs and how to meet them indicates the need to convert approximately 1,000 VA hospital beds to nursing home use each year for the next several years. To date , VA medical centers have resisted the actual undertaking of such conversions, to including those that have been called for in the DM&S' own planning process. A set-aside of $20 million annually for conversions, $40 million in FY 1990, would put an end to the claim that a lack of construction funds prevents such conversions. The VSOs hold that primary responsibility for the provision of adequate nursing home care to the nation's aging veteran population rests with the federal government.

Modest amounts of the minor construction appropriation support construction projects in the VA's Regional Offices and in existing National Cemeteries. Based on recent year's spending patterns, the FY 1990 IB projects $5 million and $10 million, respectively, as appropriate to these purposes. Finally, the IB projects $60 million in minor construction funds to be spent for the VA staff that oversees the construction process. This consists primarily of the Office of Facilities. This projection should permit the continuation of staffing at least at current levels, and demonstrates again the concern of the VSOs that the VA take steps to develop a formal institutional process that will permit assessment of construction requirements in terms of a nationwide strategy defining construction priorities.

PARKING GARAGE REVOLVING FUND

The FY 1990 IB recommends a $12 million allocation to this fund. The Parking Garage Revolving Fund is a recently established appropriation. When the fund is fully established, revenues from the parking garages, which it has financed, will pay for needed new parking facility projects; limited, new appropriations to the fund will be required. Currently, however, the fund remains in a start-up mode, with the few projects it has undertaken yet to produce revenues. In this regard, reasonable access to medical treatment is an essential element of the treatment process.

APPENDICES

APPENDIX A

MEASURING THE NEED FOR COMPENSATION, PENSION, AND EDUCATION (CP&E) STAFF IN THE DEPARTMENT OF VETERANS BENEFITS

Workload statistics compiled by CP&E are based primarily on end products (EPs) completed. There are 28 categories of end products; each category is reported separately. As a consequence, there is great potential for significant variations in workload mix. Since FY 1978, there has been a considerable change in the overall CP&E workload as reflected by total Compensation and Pension end products and total Education end products.

The following table depicts this change and the change in the number of overall CP&E positions:

The table shows that between FY 1978 and 1986, total end products decreased 28.5 percent from 7,199,586 to 5,147,182 whereas there was a 37.6 percent decrease in positions. The table shows, however, that the workload reduction as expressed in total end products was entirely in the education area, a decrease of 63 percent or 2,256,601 EPs. During the same period, there was actually a slight increase in the overall C&P workload from 3,619,540 to 3,823,737.

The gross numbers, however, do not tell the entire story. The decline in the education workload does not have a directly proportionate effect on the number of positions/FTEEs needed to accomplish the work. This is because the typical end product in the education workload does not take as long to complete as do the typical end products in the C&P workload. In this regard, DVB has developed a complex methodology for determining how many particular end products (in each category) should be completed by an employee in a year. The measurement used is called standard base weights. The base weights reflect the number of employees needed to complete

TABLE A1
CP&E END PRODUCTS AND STAFFING

FISCAL YEAR	TOTAL C&P EPs	TOTAL EDUCATION EPs	TOTAL CP&E EPs	CP&E POSITIONS
FY 1978	3,619,540	3,580,046	7,199,586	5,746
FY 1979	4,790,727*	2,981,710	7,772,437	5,637
FY 1980	4,009,395	2,771,022	6,780,417	5,002
FY 1981	3,902,106	2,676,252	6,578,358	4,727
FY 1982	4,052,901	2,281,192	6,334,093	4,488
FY 1983	3,623,869	2,153,308	5,777,177	4,183
FY 1984	3,524,003	2,011,947	5,535,950	3,912
FY 1985	3,467,820	1,523,532	4,991,352	3,764
FY 1986	3,823,737	1,323,445	5,147,182	3,583

* FY 1979 is atypical in that there were 1,008,166 more income election (150) actions than in FY 1978 (1,531,467 vs. 523,301) due to legislation.

1,000 end products, by particular categories, in a year. Thus, for example, the standard base weight for an original compensation claim is 1.74 and for an original education claim is 0.75. This means that it would take 1.74 employees to complete 1,000 original compensation claims in a year, but only .75 employee to complete 1,000 original education claims in a year. This is an extremely useful measurement tool. It permits an accurate assessment of the true percentage of C&P and Education activities in the overall CP&E workload and it takes into account the changing dynamics of the overall workload in terms of the resources necessary to accomplish the work in a timely and efficient manner. Moreover, the standard base weights incorporate productivity gains that have been achieved in the past.

Obviously, a declining (or increasing) education workload would not have the same impact as a declining C&P workload. To illustrate this, we took actual FY 1986 end products and applied standard base weights to them:

The average standard base weight for C&P end products was 0.855 (3,269,193 divided by 3,823,737) and for education end products it was 0.553 (731,697 divided by 1,323,445). Thus, although education end products represented 25.7 percent of the CP&E total (1,323,445 divided by 5,147,182), on a weighted basis, they represented only 18.3 percent of the total.

This relative disparity was no doubt greater in the past when the original compensation and pension workload (with its higher base weights) was greater. In FY 1978, for example, there were 131,225 original compensation claims and 97,331 original pension claims, whereas in FY 1986, the corresponding totals were 90,837 and 53,671. The average standard base weight for all C&P end products would therefore have been greater than now. Thus, although the overall CP&E workload declined by 28.5 percent between FY 1978 and FY 1986, there would not have been a corresponding lessening of the need for FTEEs to complete the overall workload at the same or similar level of service. Certainly a significant reduction in FTEEs was justified because of the decline in the education workload and the changing case mix within the C&P workload; however, because of the factors cited above, the VSOs believe it is clear that a 28.5 percent reduction was excessive, much less the 37.6 percent reduction that actually occurred.

To illustrate, using the FY 1986 average standard base weights (which fully incorporated productivity gains) for the FY 1978 end products, the volume of work would have been accomplished by 5,075 employees.[1] Moreover, the major difference between FY 1978 and FY 1986 workloads is that there were 2,256,601 fewer education end products. Applying the current standard base weight of 0.553 to those cases results in a weighted workload of 1,247,900 or 1,248 employees that would have been necessary to complete the work. This means that the decline in the volume of the education workload would indicate a need for 1,248 fewer positions compared with FY 1978, using current measurement techniques. However, although there were 85,265 fewer original compensation and

TABLE A2
CP&E WEIGHTED WORKLOAD
FISCAL YEAR 1986

C&P

EP	BASE WEIGHT x	END PRODUCTS =	WEIGHTED WORKLOAD
110	1.74	90,887	158,144
180	1.53	53,671	82,117
140	1.47	28,575	42,005
190	0.99	66,192	65,530
160	0.79	468,406	370,041
150	0.77	304,656	234,585
120	1.58	457,073	722,175
130	0.81	431,574	349,575
050	0.32	662,465	211,989
310	0.72	94,345	67,928
320	0.80	50,921	40,737
155	0.77	608,739	468,729
170	1.90	79,211	150,501
290	0.71	174,642	123,996
500	0.97	53,220	51,623
680	1.18	17,925	21,151
690	0.46	71,576	32,925
215	0.57	55,757	31,781
295	0.81	53,902	43,661
TOTAL		3,823,737	3,269,193

EDUCATION

EP	BASE WEIGHT x	END PRODUCTS =	WEIGHTED WORKLOAD
200	0.75	129,214	96,910
210	0.50	1,015,983	507,991
220	0.72	87,208	62,790
230	0.61	56,436	34,426
240	0.71	8,099	5,750
250	1.37	4,542	6,223
260	1.03	295	304
270	1.75	2,034	3,559
280	0.70	19,634	13,744
TOTAL		1,323,445	731,697

pension claims in FY 1986 than FY 1978, this is offset by the fact that in FY 1986, there were 204,197 more C&P end products than in FY 1978. Again, applying the current base weight of 0.855 to the increased number of C&P cases results in a weighted workload of 174,588 or 175 more employees needed to complete the volume of work. This means that the decline in the overall volume of work would justify 1,073 fewer positions (1,248 - 175) compared with FY 1978, using current measurement techniques throughout the analytical process. Based on the volume of work, CP&E positions in FY 1986 would have been 4,002 (5,075 - 1,073) instead of the actual 3,583, a difference of 419. Thus, by the most empirical method available, between FY 1978 and FY 1986, a CP&E staffing reduction of 18.7 percent would have been appropriate based on the volume of work (1,073 divided by 5,746), rather than the actual reduction of 37.6 percent.

The foregoing analysis, however, accounts only for volume; it does not address timeliness. The timeliness factor is more difficult to quantify but it is at least as important as the number of end products produced. The current level of productivity is not sufficient to provide the same level of timely service as in 1978. It must therefore be assumed that even applying current levels of productivity to FY 1978, 5,075 employees would not have been an adequate number to provide timely service. How many employees would have been sufficient to provide timely service at current levels of productivity is, of course, somewhat speculative. The VSOs believe that one-third less of the reduction would have maintained timeliness, given current productivity standards. Thus, instead of 671 fewer employees (5,746 - 5,075), 443 (671 x .66) fewer could have accomplished the FY 1978 workload in a satisfactorily timely manner. Incorporating this timeliness factor into the analysis, the new baseline measure for adequate FTEEs becomes 5,303 employees in FY 1978. Therefore, FY 1986 FTEEs should have been 4,230 (5,303 - 1,073) instead of the actual 3,583, or 647 more employees than CP&E actually had.

The Independent Budget Proposal for FY 1989 was that budget authority be provided for 3,837 CP&E positions or 424 more positions. This is based on the VSO's analysis that in FY 1986, CP&E should have had 4,230 positions. The workload estimates provided by CP&E indicate an anticipated workload of 3,303,139 C&P actions and 1,380,179 education actions. Applying the actual 1986 standard base weights of 0.855 and 0.553 to these respective actions, 445 fewer employees would process the C&P workload and 52 more employees would be needed to process the education workload for a net decrease of 393.[2] Subtracting this from the number of 1986 positions that would have been adequate to provide minimally satisfactory service, the FY 1989 staffing level for CP&E would be 3,837. (This does not include FTEEs resulting from overtime or cumulative part-time positions.)

---

[1] FY 1978 C&P EPs were 3,619,540 and Education EPs were 3,580,046. 3,619,540 times .855 equals 3,094,707 or 3,095 employees completing 1,000 cases each; 3,580,046 times .553 equals 1,979,765 or 1,980 employees.

[2] 520,598 times .855 equals 445,111 or 445 fewer employees; 93,266 times .533 equals 51,576 or 52 or more employees.

APPENDIX B

MEDICAL CARE EXPLANATORY NOTES

1. FY 1989 Medical Care appropriation as of September 30, 1989.

2. Funds required in FY 1989 to maintain the service level that existed in FY 1988 adjusted for shortfall amounts. See "shortfall" discussion, page 72. Amount based on April 1, 1989 supplemental.

3. Funds necessary to begin elimination of the one billion dollar backlog. Amount is based on an April 1, 1989 supplemental.

4. The funds required in FY 1989 to provide service at the same level as was available in FY 1988 adjusted for shortfall and equipment needs.

5. Annualization of 2. (see above) provide for a full fiscal year of funding of shortfall given the FY 1989 supplemental which would be included in the base for FY 1990.

6. Represents the cost to the VA associated with new employees and their conversion to Federal Employees Retirement System from Civil Services Retirement System, including increased social security costs.

7. The amount necessary to annualize the 4.1 percent pay raise implemented in January 1989. Whereas in FY 1989 the raise was in effect for only 9 months, the amount included here adjusts to cover the entire fiscal year.

8. The amount necessary to annualize the increase in health benefits costs that become effective January 1989.

9. An estimate of the cost of a pay raise of 4 percent effective January 1990.

10. An estimate of longevity/performance increases for FY 1990.

11. Estimated increase in health benefits costs that will be effective January 1990.

12. Miscellaneous pay items include stipend increases, federal employees compensation payments and othe small items.

13. Estimated cost of inflation for items other than personnel.

14. Facility activations-personnel, equipment and other costs related to the activation of new or remodeled facilities throughout FY 1990. See discussion, page 72.

15. Adjustment for amounts obligated in FY 1989 for equipment and other capital purchases that will not recur in FY 1990.

16. Increased payments to state veterans nursing home and domiciliaries for care of veterans.

17. Increased cost of rental property.

18. Amount needed to provide care for unanticipated workload increases related to the growing AIDS epidemic. See discussion, page 72.

19. The funding level necessary to provide the same level of health care to veterans as was provided in FY 1988. If supplemental funds are not made available in FY 1989, then the amounts shown on lines 2 and 3 must be considered as essential and included in the FY 1990 current services level.

20. Represents costs of essential improvements to the VA extended care program. See discussion, page 74.

21. Estimated costs associated with needed outpatient workload expansion. See discussion, page 79.

22. Funds necessary to provide inservice training to health professionals. See discussion, page 86.

23. The aging veteran creates demand for enhanced geriatric training. See discussion, page 86.

24. Additional requirement to begin the elimination of a critical one billion dollar backlog of medical equipment replacement in the VA system.

25. Funds necessary for the decentralized hospital computer system implementation and upgrade. See discussion, page 89.

26. Amount necessary to assure that personnel, devices and aids necessary to support the prosthetics program. See discussion, page 91.

27. Anti-Substance Act. See discussion, page 92.

28. The Independent Budget recommended appropriation to provide for an acceptable level of service to veterans in FY 1990.

TABLE 8*
MEDICAL CARE
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

			Line Number
FY 1989	APPROPRIATION	10,542,500	1
	Supplemental Funds**		
	Current services and new programs	310,000	2
	Equipment backlog	100,000	3
FY 1989	Current Services Level	10,952,500	4
FY 1990	Annualization of Supplemental Funds	410,000	5
	Payroll related increases		
	Federal Empl. Retirement System	50,000	6
	Annualization of 1989 PayRaise	70,000	7
	Annualization of 1989 FEHB	13,000	8
	Pay Raise 1990	200,000	9
	Within Grade Pay	50,000	10
	Health Benefits - 1990	40,000	11
	Misc. Payroll Items	15,000	12
	Inflation	200,000	13
	Facility Activations	200,000	14
	Capital Investment		
	Adjustments to 1989 Base	(154,700)	15
	Uncontrollable Workload Changes		
	State Home	4,900	16
	Miscellaneous		
	Property Rental	3,500	17
	AIDS	40,000	18
FY 1990	Current Services Level	12,094,200	19
	Extended Care Program	94,300	20
	Outpatient Workload Increase	100,000	21
	Postgraduate Inservice Training	6,000	22
	Geriatric Training Enhance.	1,400	23
	Equipment	100,000	24
	Decentralized Hosp. Computer Prog.	25,000	25
	Prosthetics and Sensory Aids	4,000	26
	Anti-Substance Abuse	15,000	27
FY 1990	RECOMMENDED APPROP.	12,424,900	28

**If supplemental funds are not appropriated,it would be necessary to include these amounts in recommended total.

MEDICAL AND PROSTHETIC RESEARCH EXPLANATORY NOTES

1. FY 1989 Medical and Prosthetic Research Appropriation.

2. Funds required in 1989 to maintain same level of service as 1) 1985 in Medical Research, and 2) 1988 in Rehabilitation Research and (3) HSR&D remains at FY 1989 appropriation level.

3. Total from (1) and (2).

4. Represents the cost to the VA associated with the new employees and conversion to FERS from Civil Service Retirement System and includes Social Security costs.

5. Funds to annualize the 4.1 percent January 1989 pay raise. In FY 1989, raise was in effect nine months, the amount included here covers the other three months.

6. The funds necessary to annualize the Federal Employee Health Benefits increase in effect for nine months (January 1989-September 1989).

7. Estimate of funding necessary for 4 percent pay raise in January 1990.

8. Estimated 25 percent increase of January 1990 health benefits.

9. Estimated increase in funds necessary for inflation (3.9 percent).

10. Total of all above.

11. Funds for increases in Medical Research (see page 99).

12. Funds for Rehabilitation Research increases (see page 99).

13. Funds required to annualize funds previously transferred from DOD (see page 99).

14. The amount necessary to provide a level of research funding acceptable to the VSOs.

TABLE 13
MEDICAL AND PROSTHETIC RESEARCH
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

			Line Number
FY 1989	APPROPRIATION	210,240	1
FY 1989	Supplemental Funds	14,460	2
FY 1989	Current Services Level	224,700	3
FY 1990	Payroll related Increases		
	Federal Empl. Retirement System	800	4
	Annualization of 1989 Pay Raise	1,300	5
	Annualization of 1989 FEHB	200	6
	Pay Raise - 1990	4,000	7
	Health Benefits - 1990	800	8
	Inflation	3,200	9
FY 1990	Current Services Level	235,000	10
FY 1990	Medical Research Increase	4,500	11
	Rehab Research Increase	4,700	12
	DOD Annualization	5,000	13
FY 1990	RECOMMENDED APPROP.	249,200	14

MAMOE EXPLANATORY NOTES

1. FY 1989 Medical Administration and Miscellaneous Operating Expenses Appropriation.

2. Funds to cover nine months of FY 1989 pay raise not provided in appropriation.

3. Funds to cover nine months of health benefits increase effective January 1989.

4. Funds required in 1989 to maintain same level of service as in FY 1988.

5. Represents the cost to the VA associated with the new employees and conversion to FERS from Civil Service Retirement System and includes Social Security costs.

6. Funds to annualize the 4.1 percent January 1989 pay raise. In FY 1989, raise was in effect nine months, the amount included here covers the other three months.

7. The funds necessary to annualize the Federal Employee Health Benefits increase in effect for nine months - (January 1989-[September 1989].

8. Estimate of funding necessary for 4 percent pay raise in January 1990.

9. Estimated increase funds necessary for inflation (3.9 percent).

10. Total of all above.

11. AIDS related training increase (see page 102).

12. The amount necessary to provide a level of research acceptable to the VSOs.

TABLE 14
MEDICAL ADMINISTRATION
AND
MISCELLANEOUS OPERATING EXPENSES
Components of Independent Budget Recommended Appropriation
(dollars in thousands)

FY 1989	APPROPRIATION	47,900	1
FY 1989	Supplemental Funds		
	Pay Raise	900	2
	Federal Empl. Health Benefits	100	3
FY 1989	Current Services Level	48,900	4
FY 1990	Payroll Related Increases		
	Federal Employees Retirement System	100	5
	Annualization of 1989 Pay Raise	300	6
	Annualization of 1989 FEHB	40	7
	Pay Raise - 1990	900	8
	Inflation	700	9
FY 1990	Current Services Level	50,940	10
	AIDS Related Training	3,000	11
FY 1990	RECOMMENDED APPROP.	53,940	12

APPENDIX C
VETERANS ADMINISTRATION
MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE
HOMELESS CHRONICALLY MENTALLY ILL (HCMI) VETERANS PROGRAM.
FACT SHEET no. 4

THE FOLLOWING INFORMATION REPRESENTS AN UPDATE OF KEY DATA RELATING TO THE HCMI PROGRAM.

AUTHORITY

THE HCMI PROGRAM WAS ESTABLISHED BY P.L. 100-6 IN 1987. ADDITIONAL LEGISLATION, P.L. 100-71 AND P.L.100-322, PASSED IN 1988 EXTENDED THE HCMI PROGRAM THROUGH FY.1989.

PROGRAM SCOPE

RESOURCE ALLOCATIONS BUDGET= $13,252,000 FOR FY.1989.

THE PROGRAM ELEMENTS REMAIN CONSISTENT WITH THAT REQUIRED BY P.L.100-6 :

A.)ACTIVE OUTREACH
B.)CASE MANAGEMENT
C.)EVALUATION, TREATMENT AND REHABILITATION.

A TOTAL OF 165 CONTRACTS HAVE BEEN APPROVED BY THE VA FOR PLACEMENT OF HCMI VETERANS.

THE CONTRACTS PROVIDE A TOTAL OF 213 INDIVIDUAL LOCAL RESIDENTIAL PSYCHIATRIC TREATMENT FACILITIES.

***

PROGRAM STRUCTURE

THE ORIGINAL 43 HCMI PROGRAM SITES REMAIN OPERATIONAL

Atlanta, Ga.
Bath, N.Y.
Buffalo,N.Y.
Cheyenne, Wy.
Cleveland, Oh.
Denver, Col.
Hampton, VA.
Houston, Tex.
Kansas City, Mo.
Long Beach, Ca.
Louisville,KY.
Nashville, Tenn.
New York, N.Y.
Phoenix, Ar.
Portland, Ore.
St. Louis, Mo.
Salt Lake City,Ut.
San Francisco, Cal
Tampa, Fla.
Tuskegee, Ala.
Washington, D.C.
Augusta, Ga
Boston, Ma.
Charleston,Sc.
Cincinnati,Oh.
Dayton, Oh.
East Orange, N.J.
Hines, Ill.
Indianapolis, Ind.
Little Rock, Ark.
Los Angeles (OPC)
Mountain Home, Tenn.
New Orleans, La.
Perry Point, Md.
Pittsburgh, Pa
Roseburg, Ore.
San Diego, Cal.
San Antonio, Tex.
Syracuse, N.Y.
Tucson, Ar.
Walla Walla, Wa.
West Los Angeles,Ca.

(Program structure continued.)

THE AVERAGE NUMBER OF FTEE PER HCMI SITE REMAINS AT 2.2.

HCMI SITES ARE ADMINISTRATIVELY SUPPORTED BY A VA MEDICAL CENTER.

WHILE EACH HCMI IS LARGELY INDEPENDENT IN IT'S DAILY OPERATIONS VACO PROGRAM OFFICIALS ARE AVAILABLE FOR PROGRAMMATIC DIRECTION.

THE HCMI PROGRAM FEATURES A STRONG EMPHASIS ON LOCAL COMMUNITY RESOURCES.

LINKAGE WITH TRADITIONAL VA RESOURCES INCLUDING DOMICILIARY CARE HAS PROVEN HELPFUL TO HOMELESS VETERANS.

***

WORK LOAD

OVER 10,500 HOMELESS VETERANS HAVE BEEN EVALUATED AS OF SEPTEMBER 1988.

THROUGH THE END OF JUNE, 1988 A TOTAL OF 2,395 HOMELESS VETERANS HAVE BEEN PLACED IN LOCAL PSYCHIATRIC TREATMENT FACILITIES.

APPROXIMATELY 80% OF ALL VETERANS CONTACTED BY HCMI STAFF RESULTED IN SOME VA SERVICE OR HEALTH CARE ATTENTION.

42% OF THE HCMI VETERANS SEEN BY HCMI STAFF HAD 5 OR MORE CLINICAL CONTACTS IN THE FOLLOWING 3 MONTHS.

ONLY 20% OF THE 10,500 VETERANS EVALUATED DID NOT ACCEPT SOME FORM OF VA HELP.

***

November 16, 1988

CLINICAL OUTCOMES

(THE FOLLOWING DATA HAS BEEN COLLECTED AT 9 DIFFERENT HCMI SITES AND IS BASED ON ACTUAL FOLLOW-UP CONTACTS WITH 635 VETERANS)
AT THE END OF THREE MONTHS AFTER THE INITIAL ASSESSMENT 68% OF THESE VETERANS HAD CONCLUDED INVOLVEMENT WITH THE PROGRAM.

32% HAD ACCOMPLISHED AT LEAST SOME LIMITED GOALS

10% HAD ACCOMPLISHED ONE OR MORE MAJOR GOALS IN THIS SAME TIME PERIOD.

32% CONTINUED THEIR TREATMENT FOR THREE MONTHS OR LONGER.

AT THE END OF THE FIRST THREE MONTHS FOLLOWING INITIAL CONTACT WITH THE HCMI PROGRAM ONLY 44% OF ALL VETERAN EVALUATED WERE STILL HOMELESS.

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VETERAN'S PROFILES

(based on intake population of 10,500)

ONLY 1% OF INTAKE POPULATION WERE NOT VETERANS.

OVER 70% CLAIMED TO HAVE SERVED IN WAR TIME.

30% CLAIMED TO HAVE BEEN SUBJECT TO HOSTILE FIRE.

1.7% CLAIMED POW STATUS.

95% OF THE VETERANS SEEN PRESENT SYMPTOMS OF MENTAL ILLNESS.

42% SUFFERED FROM ALCOHOL ABUSE.

7% HAD A DIAGNOSIS OF PTSD.

45% HAD A SIGNIFICANT MEDICAL PROBLEM.

22% OF THE VETERANS SEEN HAD BEEN HOMELESS FOR OVER TWO YEARS.

THE HCMI VETERANS TENDS TO BE RELATIVELY YOUNG AND HIGH SCHOOL EDUCATED.

MANY ONCE HELD RESPONSIBLE JOBS, BUT MOST OF THOSE EVALUATED HAD POOR FAMILY AND COMMUNITY SUPPORT.

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A DIFFICULT POPULATION TO SERVE

-25% ARE HIGHLY TRANSIENT.

-15% CURRENTLY ON PROBATION OR PAROLE.

-70% SPEND THEIR TIME ALONE.

-39% ARE COMPLETELY FRIENDLESS.

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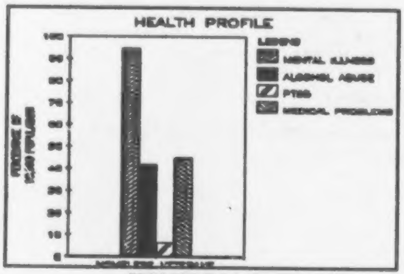
THIS DATA IS BASED ON VETERANS SEEN AS OF SEPTEMBER 1988.



HOMELESS VETERANS

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APPENDIX D

PROBLEMS IN THE VA'S CONSTRUCTION PROCESS

In recent years, the Veterans Administration has commissioned several major studies to examine its current construction process. These studies have documented multiple serious problems. As identified primarily in the "Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities", completed for the VA by Booz, Allen & Hamilton and RTKL Associates in April 1985, these problems include:

o Excessive time is required to complete construction projects;

o The users of the construction projects--the individual VA medical centers--find the completed projects don't meet their needs well;

o The choice of projects is not based on a sound system for setting priorities, and there are other inefficiencies as well; and

o The VA only deals with problems in the construction process when they become glaringly obvious in particular projects. Even then, it does not make the systematic changes to the process necessary to prevent future recurrences of the problems.

EXCESSIVE TIME

The Booz, Allen/RTKL study found that the VA routinely exceeded its scheduled time for projects by 25-50 percent, and that its schedules were somewhat longer than those of other organizations carrying out similar construction. On average, the VA was taking over 10 years from initial project development to completed construction. The study attributed this slow pace to several problems. Two notable problems were that essential information needed to begin project design was difficult to obtain and there was a lack of accountability for timely progress in the planning stage of construction projects.

The excessive time required for VA construction makes it less likely that the needs identified at the beginning of a project will still be accurate reflections of medical center needs when the project is completed. This problem often leads to major project changes during design or construction phases, which cause still further delays.

USER DISSATISFACTION

A second major problem was dissatisfaction among VA medical centers with completed construction projects. According to the Booz, Allen/RTKL study, two factors appeared to cause this problem.

First, criteria for the amount and kind of space needed for various activities in VA medical centers were not sound. As a result, the users of the space often found it did not meet their needs. Problems with the criteria include:

o Information needed for use of the criteria (principally staffing information) was often unreliable and difficult to obtain;

o Criteria in many cases appeared to be obsolete and based on assumptions that did not reflect the way health care and support services are actually provided; and

o Washington staff often insisted on applying the criteria inflexibly, with little respect for the reality of how services actually are delivered at the VA's medical centers.

Collectively, these problems underscored the need for changes in the way criteria are developed and maintained.

Second, VA Medical Center staff saw Central Office as unresponsive to their input during project design, and this resulted in time-consuming conflicts.

It seems desirable to develop procedures that more adequately accommodate users. However, some conflict between individual medical centers and Central Office may be inevitable: Each medical center focuses primarily on its own needs while Central Office is concerned with how to use a limited construction budget most effectively in meeting what it views as the highest priority needs of 172 medical centers. Also, it appears that considerable improvement in user satisfaction has occurred in response to changes put into effect since the Booz, Allen/RTKL report was completed.

UNSOUND PRIORITY SETTING AND INEFFICIENCIES

The Booz Allen/RTKL study found that neither individual VA medical centers nor the VA's Central Office had an inventory of construction needs. An inventory, it stated, should include three categories of information:

1. Maintenance and repair needs of existing structures, systems (electricity, heating, plumbing, etc.), and equipment used by medical centers;

2. Shortfalls in existing space, systems, and equipment needed for the current activities of medical centers; and

3. Shortfalls in the space, systems, and equipment that will be required by future medical center operations, as these future operations are envisaged in approved MEDIPP plans.

Without such an inventory, priority-setting is limited to a choice among projects that happen to be on lists submitted by medical centers (the Five-Year Facility Plans). These projects may or may not address the needs which the VA as a whole sees as having highest priority. The focus of the recently completed Capital Facilities Study is too narrow to serve as an inventory in the sense described above.

At individual medical centers, the report also found that "poor coordination between current projects and future construction needs leads to design solutions that close off future options for development. In some cases, recent construction has even had to be replaced to meet new construction needs."

FAILURE TO ADDRESS PERFORMANCE PROBLEMS

"Problems in the VA construction process often reach major proportions before they are identified by top management and effective corrective actions are taken," according to the Booz, Allen/RTKL Study. "In many cases, even when significant problems exist, they come to the attention of top management only after they have been identified by outside organizations (e.g., OMB, GAO, Congress)."

"A lack of standards and indicators for measuring...." performance in the construction process appears to be the primary problem. "Because of the lack of standards, there is no information to evaluate...aspects of performance...." such as quality, timeliness, or cost, and VA top management "is forced to review detailed project-level information to monitor overall...performance" rather than having indicators it can track.

The report also found "a general perception in the VA that each construction project is unique and that the VA's health care facility construction process is completely different from...." health care facility construction outside the VA. As a result, indicators that are available and appropriate--such as cost per gross square foot for various types of construction--are not used. "The result is poor performance...." in important aspects of the construction process such as timeliness, cost, and quality.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
OF THE
U.S. HOUSE OF REPRESENTATIVES
February 7, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have the opportunity to appear here today to discuss the Budget request of the Department of Veterans Affairs (DVA) for Fiscal Year 1990.

As you are aware, Mr. Chairman, on behalf of the Department of Veterans Affairs the President is requesting $28.6 billion -- a decrease of $575 million from the Fiscal Year 1989 funding level -- to administer the various programs and services for this nation's 74.4 million veterans, their family members, and survivors of deceased veterans in Fiscal Year 1990.

As you are aware, Mr. Chairman, the creation of the Independent Budget is a joint effort by several veterans service organizations. The processes employed to create this document are, as you can well imagine, complex and require a great degree of expertise covering the broad spectrum of VA benefits, services, and programs.

In order to ease our efforts to the greatest degree possible, each of the participating veterans service organizations have agreed to take full responsibility for a single element of the budget.

The DAV's area of responsibility is the Veterans Benefits Administration (VBA). At this point we wish to present testimony in a rather comprehensive and broad fashion relating to both the Administration and the Independent Budgets proposed Fiscal Year 1990 budget request for VBA.

Veterans Benefits Administration (VBA)

The DVA's FY 1990 request for VBA totals $548.8 million, an increase of $33 million from the FY 1989 appropriated level.

In analyzing the budget request, our primary concern is that the requested appropriation will support an average employment of 12,100 FTEE, a decrease of 550 FTEEs from the FY 1989 current estimate. It must be noted, however, that the FY 1989 appropriations bill directed VBA to maintain an employment level of not less than 12,898 FTEEs. The requested FTEE level for FY 1990 is therefore a reduction of 798 FTEEs from the number mandated by Congress in the enacted appropriation bill for FY 1989.

Mr. Chairman, with this major reduction in FTEEs, it would be logical to assume that VBA was functioning in an exceptional manner. Reducing FTEE levels is, after all, the budgetary payoff for an organization that is delivering excellent service in all areas of its operation and has the mechanisms in place to ensure that at least the same level of excellent service will be maintained with fewer FTEEs. On its face, then, the Administration's FY 1990 budget request should lead to the conclusion that all is well with VBA and that veterans and their families are having the Congressionally-authorized programs which VBA administers delivered to them timely and accurately.

An analysis of the state of VBA's delivery of service to veterans demonstrates that these expectations, which reasonably follow from the budget request, are an exercise in fantasy. The fact is that this budget request, like previous ones, has no relationship whatsoever to a goal of providing even minimally adequate service to veterans. Otherwise, how can the following facts, which directly relate to service delivery, be explained:

o In Compensation, Pension and Education (CP&E):

In 1979, VA standards called for 75 percent of original compensation claims to be completed within 90 days. The standard is now 50 percent and is not even close to being met. As of August 31, 1988, only 27.9 percent of original compensation claims were completed within 90 days. The situation will get worse because:

- With current resources, VBA's projection is that the number of pending C&P cases will quadruple between the period October 1987 and October 1989 (from 167,687 to 683,451).
- Quality has deteriorated as evidenced by a significant increase in the substantive error rate, yet there is no centralized, standardized program training or funds specifically earmarked for program training.
- C&P (and VBA as a whole) is saddled with outmoded, labor-intensive work processes because of a failure to implement a coherent and definitive plan for systems modernization and a corresponding lack of funds for that purpose,

In Veterans' Services there is:

- An abandoned call rate (veterans unable to get through to a VBA employee), of nine percent which equates to over one million telephone calls that go unanswered.
- A decrease in the FY 1989 estimate of 363,461 telephone interviews from the FY 1987 actual, no doubt due to many veterans giving up trying to reach the VBA.

In Vocational Rehabilitation and Counseling:

- The average elapsed time for a veteran to be successfully rehabilitated has increased by 65% from FY 1984 (255 days compared to 155 days).
- Eligible veterans must wait 90 days for an initial interview.
- Much needed new positions (employment specialist) were authorized in 1987 (after a seven-year delay) but none have been filled.

In Loan Guaranty:

Compounding the economic factors which have caused a major increase in the number of loan defaults, program costs are significantly higher than they should be because of:

- A decreased cure rate of loans in default.

- The issuance of bad loans.
- Poor appraisal practices.
- Poor maintenance of foreclosed homes.
- Poor marketing techniques.

In Support Services:

The deterioration in timeliness is caused in part by backlogs in the non-adjudicative functions of case processing. Adjudication and supervisory staff are being used routinely to perform clerical tasks because of these backlogs.

Mr. Chairman, given these facts, the DAV does not believe that anyone would be foolish enough to say that veterans are being provided good service -- even VBA.

In this regard, it is interesting to observe that for years (including FY 1989), the VBA components' budget justifications would include the statement, "The requested FTEE level for (year) will provide continued good service to our veterans." The statement does not appear in the FY 1990 budget justifications. In our testimony last year and in last year's Independent Budget, we documented the sorry state of service to veterans, as we are doing today, and with the true situation confronting VBA having been brought to light, it appears the VA is no longer willing to maintain the hypocrisy that requested appropriations can even remotely be expected to provide good service to our veterans. We can only wonder if the fiction that the Administration's budget requests have any direct connection to addressing the needs of veterans will similarly be discarded.

It is beyond dispute that service to veterans is woefully inadequate in general. Let's examine how the FY 1990 VBA budget addresses the problems described above. In order to describe the impact of the FY 1990 budget, however, it is essential that it not be viewed in a vacuum. It is merely the latest of a series of ill-advised and inadequate budget requests that have victimized veterans.

Compensation, Pension, and Education

Since 1978, the FTEE level has been slashed by almost 40 percent. For FY 1990, a further reduction of seven FTEEs is requested. Those desperately looking for silver linings will welcome the news that a reduction of hundreds of FTEEs is not being requested as has happened routinely in prior years. The fact, however, is that with this FTEE level, the October 1987 compensation and pension backlog will quadruple by October 1989, to almost 700,000 cases. The cumulative results of a series of inadequate budgets are now in place and it is inevitable that the downward spiral of deteriorating service will accelerate. With this FTEE level, one can only imagine what the backlog projection will be next year. For example, the backlog projection for October 1989 made by VBA in connection with the FY 1989 budget was 259,156; the current projection for October 1989 is 683,451.

Mr. Chairman, the direct relationship between increasing backlogs and decreasing timeliness is inescapable. With the current FTEE level, it is doubtful if any veteran filing a compensation claim today would receive a decision within 90 days (established VA standards).

There are some indications that the prodding and pleas of this committee and the VSOs have had some effect on the

Administration's budget request. As you recall, last year, both the committee and the VSOs strongly urged that funds be appropriated for centralized program training and Automated Data Processing (ADP) modernization. Appropriations for these essential activities were neither requested nor provided in connection with the FY 1989 budget. For FY 1990, however, the Administration is requesting appropriations to support a centralized training staff of five FTEEs and $25.1 million for ADP improvements.

This is encouraging but the DAV believes that a much larger training staff is required to train not only the large number of new employees needed but to provide refresher training for experienced adjudication personnel. Moreover, funding for training and improved systems cannot wait for FY 1990; it is clear that funding for these initiatives are not only great but immediate.

Veterans' Services

Despite the fact that hundreds of thousands of veterans are unable to reach a VBA employee by telephone and the strong indications that many others have given up trying to call, the Administration is requesting a reduction of 91 FTEEs in Veterans' Services.

Vocational Rehabilitation and Counseling:

Current staff obviously are overburdened and unable to provide adequate service yet the Administration requests a reduction of 5 FTEE.

Loan Guaranty

Everyone (except, apparently, OMB) recognizes that additional FTEEs would generate tremendous program savings. Program costs are considerably more than they should be because the existing staffing level is insufficient to provide adequate service. Here, good service and program savings are directly related to each other. Additional FTEEs are desperately needed to improve VBA's performance in preventing and curing defaults and increasing the sale price of properties through effective property management. Improved service in these areas is indisputably cost effective.

The Administration's response in the FY 1990 budget is to request a reduction of 45 FTEEs.

Support Services

Mr. Chairman, notwithstanding the problems identified above, the Administration is requesting a reduction of 335 FTEEs in Support Services. The reduction reflects a transfer of 187 FTEEs from Support Services to the Medical Care appropriation. While additional FTEEs are unquestionably needed in Medical Care, this appears to be a case of robbing Peter to pay Paul. The remaining reduction, according to the VBA, reflects employment savings in 1989 and 1990 from short-term modernization initiatives. Considering the administrative function of Support Services' contribution to the rapidly deteriorating timeliness of claims actions and the well-documented fact that adjudication and supervisory personnel are routinely required to perform clerical tasks, the DAV has great difficulty in believing that the substantial reduction in FTEEs requested has any rational justification, especially the

106 FTEE reduction in the administrative function of Support Services.

In summary, Mr. Chairman, our assessment of the proposed FY 1990 VBA budget is that it has been formulated without any concern for addressing the real needs of veterans. We are convinced that the Administration's budget formulation process no longer has as its goal an assessment of the resources needed to deliver Congressionally mandated programs to veterans in a timely and qualitative manner.

It is vital that Congress have the information relating to the true state of the VBA's delivery of service to veterans and how it compares to the reasonable expectations of veterans and Congress, in order to determine what resources are needed to restore and maintain adequate service within a climate of fiscal austerity. Because the VA continues to be unable or unwilling to provide this data, the VSOs have again proposed an Independent Budget. We would like to briefly summarize the analysis and recommendations of the VSOs concerning the VBA.

Independent Budget (IB) Recommendations

Mr. Chairman, we would first like to observe that it is a sad state of affairs when there is an obvious need for an IB. The need exists because the VA has abdicated its responsibility to formulate and present to Congress a realistic needs-based budget.

For a maximum impact, the IB should mirror the format of the VA's budget justifications because the contrast between the VSO's and the VA's analysis and recommendations can then be glaringly apparent. In preparing such a budget, however, the VSOs are confronted with some obstacles and limitations. Let me explain what we mean.

We can, of course, independently identify veterans' needs and assess the VA's performance in providing service to meet those needs. Using historical data and common sense, we can define adequate service in terms of specific workload-oriented goals for the components within VBA and provide a general assessment of the resources needed to meet those goals. We can also give informed estimates on specific resource needs (and their costs) and in some instances, for example, in CP&E and VR&C, we have the data and knowledge to state with precision what resources are needed to restore adequate service to veterans.

However, there is a point where the VSOs (and Congress) simply do not have and should not be expected to have the means to do the job that the VA is supposed to be doing. For example, where service levels are clearly deficient, Congress needs to know what the true costs are of restoring adequate service. This requires an in-depth management and program analysis which only the VA is now in a position to provide. To be more specific, using Loan Guaranty as an example, an informed budget formulation process should include such factors as:

- The actual and associated costs of the current level of services, i.e.:
    - How many "bad" loans are issued and what is the average program cost for each;
    - How many loans in default could have been prevented by counseling that was not provided and the average cost for each;

- How many properties have been erroneously appraised and at what cost;
- How much has the average sale price of properties been reduced because of poor maintenance and marketing techniques; and
- How many loans in default could be cured if meaningful counseling and assistance were provided to veterans whose loans are in default.

All of these factors result in quantifiable costs for which appropriations are or will be needed. Responsible budget formulation should be directed to identifying cost-effective measures that will improve service and, therefore, reduce overall appropriations. The relevant questions are:

What are the optimum resources needed to achieve a balance between good service to veterans and cost-effectiveness?

What impact would additional FTEEs have on program savings, e.g., how many FTEEs are needed to improve the default cure rate by 1%, by 2%, etc. and what are the personnel costs versus the program savings?

What improvements can be made in work processes either through management initiatives or enhanced technological capabilities? What are the costs and what savings can be expected?

What are the projected out-year savings, both program and administrative, resulting from the additional resources being requested?

Mr. Chairman, we submit that this is the manner in which budget formulation should be conducted. The primary recommendation of the IB is for Congress to direct the VA to use this methodology in their budget justification. The baseline for budget formulation must be a definition of what constitutes good service, expressed in specific and measurable workload-oriented goals. The budget analysis would then be focused completely on realistic assessments of the resources needed, given effective management and employee efficiency, to meet the good service goals. The IB follows this methodology and we hope it can serve as a model to Congress of informed and responsible budget-making.

As we have indicated, however, the VSOs do not have the resources to precisely determine the amount of the actual and associated dollar costs resulting from a series of ill-informed and inadequate administrative budget requests with the resultant outmoded work process and inefficient service delivery, although we are painfully aware of the cost to veterans in terms of inadequate, delayed and, in too many instances, nonexistent service. Neither do we have the resources to precisely determine the savings (both short and long term) that would occur if appropriations are provided that will permit the delivery of good service in an efficient manner. The VSOs are confident, however, that just as last year the myth that the VA was providing good service to veterans was destroyed, this year's IB will destroy the myth that arbitrary budget cuts save money.

The fact is that those cuts have been tremendously costly. An excellent indicator of exactly how costly these cuts have been is a comparison of the administrative costs of the Social Security Administration (SSA) for the delivery of benefit payments with the VA's General Operating Expenses (GOE), the account that funds VBA's operations. Expressed as a percentage of benefit payments, SSA's administrative costs are 1.2 percent; VA's are 4.8 percent. Certainly, the size and complexity of the benefit program administered by SSA are at least as great as those administered by the VA, yet the percentage of administrative costs needed by VBA to inadequately deliver benefit payments is more than three times greater than SSA's. It is also interesting to note that SSA is now expanding service to the public while reducing FTEE levels.

Mr. Chairman, the initial costs of the IB recommendations for additional appropriations should be viewed within this context, i.e., that they are cost effective. In this regard, we are confident that the program savings resulting from increasing the FTEE for administering Loan Guaranty would, alone, go a long way toward offsetting the immediate costs of our recommendations in other GOE areas.

The FY 1990 IB recommends that a FY 1989 supplemental appropriation of $23.9 million be provided for VBA and allocated as follows:

- $2,076,000 for an increase of 130 FTEEs in veterans' services for a total of 2,276
- $3,390,000 for an increase of 215 FTEEs in compensation, pension and education for a total of 3,852
- $236,000 to support a centralized training staff of 15 FTEE
- $2,006,000 for an increase of 140 FTEEs in Loan Guaranty for a total of 2,240
- $1,202,00 for an increase of 61 FTEEs in Vocational Rehabilitation and Counseling for a total of 714
- $15 million for enhancements of ADP systems.

We are recommending these supplemental appropriations because, as we have already demonstrated, the need is great and immediate. Solutions to the massive problems in VBA must be addressed in the current fiscal year.

For FY 1990, we are recommending:

- An increase of 250 FTEEs in CP&E for a total of 4,117 (including training personnel)
- In Support Services we are recommending that staffing for the administrative function be maintained at 1,536 FTEEs and not cut to 1,422 as requested by the Administration.

Our service delivery goals for the components we are recommending receive additional staff are:

- Veterans' Services - Reduce the abandoned call rate to five percent by the end of FY 1989 and to two percent by the end of 1990.
- CP&E - Reduce the pending CP&E workload to the October 1987 level of approximately 170,000 by the end of FY 1990; meet or exceed all "acceptable" timeliness standards for the disposition of end products (EPs) by the close of FY 1990.
- Loan Guaranty - Improve the cure rate percentage of loans that are in default to the FY 1983 rate of 85

percent (from a FY 1987 level of 77 percent) by the close of FY 1990.

- VR&C - Reduce the Vocational Rehabilitation Specialist case load to an average of 125 and reduce the Counseling Psychologist case load to an average of 20 by the end of FY 1990. This should result in significant reductions in the time a veteran must wait for an initial interview and the time it takes for the veteran to be successfully employed.

Mr. Chairman, I am sure you will agree that these goals are modest. They represent a resigned but impatient acceptance that the OMB-dominated budget process has caused a crisis so deep that even minimally adequate service to veterans cannot be restored overnight. But we must at least reverse the trend of accelerating deterioration of service and we must do it now.

In conclusion, once a responsible and realistic budget process, as described, has been implemented, the DAV expects solutions to be developed rapidly. The expertise of the VBA will then finally be released and the equation between adequate, efficient and focused resources and cost-effective delivery of good service can once again become the centerpiece of budget formulation.

Medical Care

The Fiscal Year 1990 request for the Veterans Health Services and Research Administration (VHSRA) calls for overall budget authority in the VA's medical care account of $10.7 billion -- an increase of $198.9 million over the Fiscal Year 1989 level.

Mr. Chairman, notwithstanding the proposed funding increase, the VA's ability to provide quality and timely health care services to America's veterans -- including those veterans with mandated eligibility for health care services -- will continue to erode should the administration's proposal for the medical care system be accepted and enacted in its current form.

In our view, this would occur due to at least a decade of decremental funding levels requested by the Administration which has, in the last half of Fiscal Year 1988 and continuing into Fiscal Year 1989, forced the health care system into the grips of a budget shortfall rapidly approaching $1 billion.

Mr. Chairman, the adverse ramifications of this budget shortfall were vividly revealed at a September 7, 1988 hearing before the Subcommittee on Hospitals and Health Care.

At that time documented instances of restricted health care services were described by witness after witness. Additionally, numerous VA employees, including Medical Center Directors, Chiefs of Staff and nurses located in various facilities across the country presented a realistic, albeit bleak, portrait of a daily struggle just to provide the bare minimum of quality health care services to veterans with mandated entitlement.

We continue to be advised by veterans that services are still denied or rationed. Most disturbing, these reports are occurring in larger numbers and with greater frequency.

According to the documents with which we have been provided, the Administrations budget request proposes, among other things:

*a reduction of more than 8,500 FTEE;

*a reduction of $355.5 million related to certain management, productivity, and program improvements (including a "one percent productivity increase" which, in reality, is nothing more than an arbitrary 1% budget reduction; and

*a net reduction of $27.8 million and 659 FTEE for the Decentralized Hospital Program.

Additionally, Mr. Chairman, the budget further proposes:

*treating 17,516 fewer veterans in VA hospitals;

*treating 7,983 fewer veterans in nursing homes;

*treating 6,269 fewer veterans in domiciliaries; and

*continuing the disturbing pattern of operating fewer (3,161) VA hospital and nursing home care beds than mandated by current law.

According to some estimates, the proposed medical care budget for Fiscal Year 1990 falls close to $1 billion (if a Fiscal Year 1989 supplemental is not forthcoming) short of the minimum funding level necessary to maintain veterans health care services at Fiscal Year 1988 levels.

Mr. Chairman, we encourage you and members of the Committee to carefully scrutinize the Fiscal Year 1990 funding levels proposed for the medical care account. We believe such scrutiny will lead you to propose a realistic and meaningful funding level that will, at the very least, enable the Department to provide health care services to those veterans so entitled by law.

In this respect, Mr. Chairman, we would further urge you to carefully consider the recommendations and funding levels as contained in the Independent Budget for Veterans which has been provided to the Committee. This budget document represents the cumulative and cooperative efforts of several major veterans' service organizations (DAV, AMVETS, VFW, and PVA) and represents, in our view, a realistic funding level that would allow the Department to carry out its mandated mission of providing health care services to disabled veterans.

Medical and Prosthetic Research

Mr. Chairman, the Administration's Fiscal Year 1990 medical and prosthetic research budget request is $197.3 million, $12.9 million below the Fiscal Year 1989 funded level with a reduction at 616 FTEE.

The DAV has, and continues to be, fully supportive of the VA's combined research efforts. Not only has this activity greatly alleviated the pain and suffering of countless service-connected disabled veterans, it has also provided the means to help restore many of them to being productive, taxpaying workers. Moreover, the results of VA research activities have benefited society as a whole.

It is discouraging, therefore, to continue to witness Administration appropriation requests that can only greatly impair the effectiveness of these activities. We think that the Independent Budget's recommended appropriation of $249.2 million for combined research activities is needed to restore vitality to the VA research activities.

Construction

The Administration's Fiscal Year 1990 construction request totals $487.6 million. Mr. Chairman, while we support full funding of the VA's request for construction purposes, we are nevertheless concerned that the requested amount will not meet the pressing needs of the health care system, especially since the proposed level of funding falls $13 million below the Fiscal Year 1989 level.

As you know, greater numbers of elderly veterans are seeking nursing home care from the VA, yet, in this construction budget proposal no funding has been requested for new nursing home care bed construction. Additionally, we are concerned that this construction budget request fails to adequately recognize the replacement and modernization needs of the VA's many aging health care facilities. In this regard, Mr. Chairman, we urge the Committee to favorably consider the construction recommendations of the Independent Budget.

We have noted and support the VA's proposal to convert 363 hospital beds to nursing home care beds. However, in so doing, we would urge the Administration to move swiftly in the conversion process and, when and where indicated, identify additional acute care beds that may realistically be converted to nursing home care. In doing so, we trust an appropriate balance will be maintained to meet the acute, intermediate and long-term health care needs of our rapidly aging veteran population.

We are extremely pleased and supportive of the proposal to request funding ($9.3 million) for the VA/DoD joint venture in constructing a Medical Center at Nellis Air Force Base, Las Vegas, NV. In our view, this represents an excellent, efficient and cost effective way to move in the direction of meeting the health care needs of veterans. We firmly believe expansion of these types of sharing programs are urgently needed and beneficial to all involved.

PROPOSED LEGISLATION

The Administration's Fiscal Year 1990 budget request proposes legislation that would provide for:

(1) an increase of 3.6% in the rates of disability compensation and Dependency and Indemnity Compensation (DIC), effective December 1, 1989;

(2) indexing compensation benefits to the annual change in the Consumer Price Index;

(3) changing current law to provide for the VA plot allowance to be paid only in the case of those veterans who were either in receipt of VA compensation or pension benefits at the time of death or to wartime veterans who died without sufficient resources for burial;

(4) amending current law to permit lender/borrower negotiated interest rates on VA guaranteed home loans;

(5) repealing authority for the Education Loan Fund;

(6) increasing the per diem paid to state veterans homes;

(7) government-wide credit reform -- directly impacting on the VA Home Loan Guaranty Program;

(8) increasing dependents assistance allowances (Chapter 35) and vocational rehabilitation subsistence allowance (Chapter 31) by 5%, effective January 1, 1990;

(9) increasing from $500 to $1000 the limit of dental treatment that may not be performed on a fee basis without acquiring a second opinion;

(10) permitting dental treatment to be performed on an outpatient basis to certain veterans scheduled to receive hospital treatment;

(11) amending existing law to limit reimbursement of beneficiary travel expenses to veterans who reside more than 100 miles from a VA Medical Center or who require special means of transportation;

(12) requiring additional co-payments by certain veterans (categories B & C) receiving outpatient care and VA prescriptions; imposing a per diem payment for inpatient treatment; and permitting reimbursement by health insurers for service connected disabled veterans rated 0% to 20% who receive VA care for non-service connected disabilities;

(13) implementing the loan guaranty program operational improvement program (LPS);

(14) increasing the loan guaranty funding fee from 1% to 3.8%, effective October 1, 1989; and

(15) sell loans with or without recourse.

Mr. Chairman, the DAV is pleased with the Administration's proposed cost of living adjustment in the rates of disability compensation and DIC benefits -- in recognition of the special consideration service-connected disabled veterans and their survivors should be given.

Accordingly, the DAV strongly supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost of living adjustment in line with the rise in the Consumer Price Index, effective December 1, 1989.

As strongly as we support this rate increase, we adamantly oppose any effort to index compensation benefits to the annual change in the Consumer Price Index.

Mr. Chairman, in our view, the many and complex benefit programs administered by the VA deserve and, in fact, require continuous oversight scrutiny by the Congress and, specifically, the Veterans Affairs Committees.

Any attempt to index compensation benefits is, in our view, an attempt to diminish the oversight functions of the Congress. Such a result would not be in the best interest of the VA or, more importantly, the beneficiaries they are mandated to serve.

Additionally, we view the initiative to "standardize" the eligibility for the VA plot allowance as simply another example of an Administration effort to repeal an entitlement that has been bought and paid for by honorably discharged veterans. Accordingly, the DAV opposes this legislative proposal.

Mr. Chairman, the Administration is again proposing to remove the Administrator's authority to set the interest rates on VA guaranteed home loans. We are opposed to this, for, should this occur, interest rates would then be dictated by mortgage lenders at, we suspect, a level significantly higher than would be set by the Administrator. Without doubt, all veterans, including service-connected disabled veterans, would be adversely affected by such a procedure.

Also, Mr. Chairman, the Administration is again seeking the enactment of government-wide credit reform legislation.

Mr. Chairman, contrary to the information provided in the Administration's budget documents (attempting to justify their credit reform proposal), it would appear that the real purpose of the reform is to limit all new loan obligations in the near term with the ultimate goal of virtually eliminating all such federal programs. We do not believe this reform to be in the best interests of veterans.

The DAV is pleased with the Administration's proposed increase in the benefits paid to Chapter 31 and Chapter 35 beneficiaries and strongly supports the enactment of legislation to accomplish this proposal.

Our initial reaction to the proposal permitting dental treatment to be performed on an outpatient basis is favorable in that veterans will receive the treatment they require without the more costly requirement that they first be admitted as an inpatient. However, we are withholding our support until clarifying information is forthcoming satisfying our concern that veterans requiring dental treatment will actually receive it on an outpatient basis.

As you are well aware, Mr. Chairman, Public Law 100-322 contained a number of provisions designed to accomplish an equitable administration of the beneficiary travel program.

It is incredulous to again witness the Administration's attempt to "tinker" with this program to the obvious detriment of veterans seeking health care services. We strongly urge the Committee to reject the Administrations legislative proposal imposing additional restrictions to this program.

Likewise appalling are the proposals that would require; (1) additional co-payments be imposed on Category B & C veterans receiving outpatient care ($5, and $10 respectively); (2) veterans be charged for prescriptions ($3 and $5 respectively); and, (3) a per diem payment ($9) be assessed for inpatient treatment.

Clearly, Mr. Chairman, such a proposal has the underlying theme of structuring the veterans health care system to parallel that of the private sector.

A secondary purpose exists, in our view, to simply force a large number of veterans away from the VA thus diminishing the base and patient mix of veterans able to utilize the system. The end result; a deliberate and purposeful attempt to dismantle the system to a point of ineffectiveness. Simply stated, we view this proposal as an attempt to require veterans to pay for the privilege of utilizing earned VA benefits and entitlements. The DAV vehemently opposes this proposal and would urge the Committee to reject it.

Mr. Chairman, we have noted with a great deal of curiosity the Administration's estimate that in Fiscal Year 1990 some $304 million will be collected, based on third party reimbursements and the imposition of co-payments, in the medical care account.

We are skeptical of this figure for two general reasons:

1.) Currently, the VA is in the process of denying care to "discretionary patients", category B & C veterans, a practice which will become more frequent in the coming months. (These patients form the pool of veterans from which these type of Proprietary Receipts are generated.)

2.) As we understand it, in Fiscal Year 1988 the VA billed insurers a total of some $275 million and received reimbursement in the sum of approximately $105 million (less than 40% of the total amount billed).

Mr. Chairman, we would be very interested, as I'm sure you are, as to how the VA has arrived at the $304 million figure.

We are encouraged to note the VA's desire to implement the Loan Guaranty Program Operational Improvement Project (LPS). As we understand it, the LPS is designed to automate and streamline several aspects of the Loan Guaranty workload processes.

However, we are extremely concerned over the projected loss of 177 FTEE due to the implementation of the LPS. We believe it very unwise to assume, as the VA apparently has, that fewer employees are required prior to an automated program being implemented. Therefore, we urge the Committee to restore these FTEE.

Finally, Mr. Chairman, we would take this opportunity to register our opposition to the Administration's proposal calling for an increase -- from 1% to 3.8%, effective October 1, 1989 -- in the loan guaranty users fee.

The DAV has repeatedly expressed serious reservations regarding the requirement that veterans pay for the privilege of using an earned VA benefit. We do so again at this time.

However, Mr. Chairman, should such an increase in the users fee receive consideration by the Committee, we strongly urge the favorable consideration of continuing the exemptions for service connected disabled veterans, including those who are non-compensable as well as for certain surviving spouses currently exempted.

In conclusion, Mr. Chairman, as we have noted several times during the course of our testimony today regarding the VA's proposed Fiscal Year 1990 budget, we strongly endorse the combined effort of several veterans' service organizations. That effort is the Independent Budget for Veterans.

In our view, the Independent Budget represents a realistic assessment of the VA, its programs and the beneficiaries it is mandated to serve. We strongly urge you, Mr. Chairman, and the members of the Committee to favorably consider the Independent Budget and recommend to the Budget Committee funding levels that truly reflect the needs of all VA benefits, programs and services.

STATEMENT OF
R. JACK POWELL, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
PROPOSED FISCAL YEAR 1990 BUDGET FOR THE VETERANS ADMINISTRATION
AND THE NEED IS NOW: AN INDEPENDENT BUDGET BY VETERANS FOR VETERANS' PROGRAMS FY 1990
FEBRUARY 7, 1989

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to express our views on the Reagan Administration's proposed Fiscal Year 1990 Budget for the Veterans Administration.

The Veterans Administration finds itself in a fiscal crisis. This condition is the direct result of chronic underfunding and unrealistic assessments of demand which have gone unchecked for the past several years. Testimony from VA Medical Center Directors and upper level medical system managers last September, before this Committee and the Senate Committee on Veterans' Affairs, graphically indicated the unprecedented nature of this problem. The VA is clearly in deep trouble.

What is happening to the Veterans Administration health care system is not apparent to the casual observer. But it is obvious to poor and aged veterans who by the thousands are losing access to health care. Those veterans losing access to services are veterans who have no alternative to the VA - those who are chronically ill and need medical monitoring, outpatient care, nursing home care, domiciliary care, prescriptions, supplies and prosthetic equipment.

The VA might argue that "every eligible veteran is receiving care." But we would counter: what type of care? what degree of care? how timely is that treatment to meet true health needs?

The VA itself, last September, admitted to having a funding shortfall for this fiscal year in excess of $600 million. The Independent Budget estimates this shortfall to be in excess of $1 billion when counting the cost of deferred purchases of updated medical equipment for the system. But, if this shortfall does exists, which it does by the Agency's own admission, how can they say that they are adequately meeting true and current service levels to provide adequate care for all eligible veterans? The answer is they cannot. And, in our opinion, they are not providing that care. Outright denial of care is illegal and can not be tolerated. Intentional delay or restriction of services due to inadequate resources is much more insidious; it is outright dangerous - life-threatening.

Continuing shortfalls in funding have resulted in the inability to recruit needed staff and the closure of thousands of beds. Expensive medical care, such as hip replacements are being denied eligible veterans. Outpatient care has been reduced and rationed in instances where a follow-up outpatient visit is obviously needed. Such instances seriously endanger the health of the veteran patient.

The Fiscal Year 1990 Budget proposed by the Reagan Administration completely ignores this funding crisis. If approved intact by the Congress, this recommendation would add another yearly layer to the VA's deficit, sinking the agency deeper into debt on top of shortfalls that have compounded regularly over the past several years. The problem as we see it stems from a complete failure on the part of the Office of Management and Budget to recognize and admit the true needs of the VA and the veteran patient population it serves. Documents which surfaced from OMB in 1980 stated very clearly their rationale in proposing the first massive reductions in VA health care funding at that time. Their objective was "to shrink (the VA) system size slowly."

Subsequent budget proposals have shown that OMB has not deviated from this course. In fact, it is their fiscal strangulation of the system which has created the crisis the VA is experiencing at the present time. OMB budget proposals are made by accountants, setting dollar targets in complete disregard of the advice and recommendations of the health care professionals and health care planners in the VA at all levels of the system, who know what the Department of Medicine and Surgery needs to meet current and projected workloads. The VA spends millions of dollars on planning - a projected $40 million is to be spent on the new Facilities Development Planning Process designed to project future construction needs. But, of what use is all this effort and expenditure if OMB does not provide adequate resources to pay for these items?

In their desire to "shrink" the VA health care system OMB completely forgets that veterans do not stop becoming ill, incapacitated or disabled merely because the VA does not have the resources or facilities to provide health care for them. A "reduced" VA provides no cost savings, but only cost shifts as veterans, mostly needy and indigent veterans, are forced to seek care from other federal, state or private health care providers. The sad factor in this scenario was revealed in PVA's recent study "VA Health Care: Actions and Interactions." In many instances these other sources of care are not able to absorb this increased demand - a veteran must then go without proper health care and reflects a total abdication of responsibility by government.

Mr. Chairman, for the third year in a row, Paralyzed Veterans of America has worked with AMVETS, Disabled American Veterans and Veterans of Foreign Wars to develop an independent assessment of the budget needs of the VA. This document which analyzes all aspects of VA funding is entitled this year: "The Need Is Now: An Independent Budget by Veterans for Veterans Programs." We believe this Independent Budget gives ample explanation of how the VA got into the fiscal shape it is in. It then makes responsible recommendations to serve as solutions to the problem. We encourage you to review this proposal carefully. The following summary illuminates certain dangers included in the Reagan Administration's budget proposals and provides evidence of the major areas we feel need to be corrected, predicated on the detailed information contained in the Independent Budget. A line-by-line analysis of our recommended budget, with explanations of each expenditure, is attached to this testimony. I ask that the entire "Independent Budget" be included in the hearing record.

Medical Care

By all accounts, the VA medical programs suffered a shortfall in program funding this fiscal year of more than $625 million. The original shortfall estimate from the Department of Medicine and Surgery, prior to Congressional approval of the FY 1989 VA Appropriation was approximately $840 million. The appropriation reduced that shortfall with the inclusion of additional funding of $215 million to $625 million. At the present time, the Independent Budget recommends that $410 million be restored to the budget base in the form of a supplemental to bring funding levels for medical care up to a current services level for the remaining months of this fiscal year.

The following is a summary of recent VA appropriations, Independent Budget recommendations for this fiscal year and fiscal year 1990, as compared with the Reagan Administration's proposed budget.

VA APPROPRIATIONS SUMMARY
(dollar in thousands)

Appropriation Account	1988 Appropriation	1989 Appropriation	1989 IB Current Services*	1990 IB Current Services*	1990 IB Reccommended Appropriation	1990 Reagan Admin. Proposal
General Operating Expenses and Misc.	774,810	783,320	830,460	873,960	910,160	830,164
Benefits Programs	16,571,300	17,063,670	17,123,670	17,497,400	17,497,400	16,268,546
Medical Programs	10,409,960	10,843,140	11,268,600	12,422,640	12,770,540	11,029,782
Construction Programs	522,900	500,640	501,540	502,540	921,920	487,623
TOTAL VA APPROPRIATION	28,278,970	29,190,770	29,724,270	31,296,540	32,100,020	28,616,115

*Funds necessary to maintain services at the FY 1988 level.

Total appropriations for the VA in FY 1988 were $28.3 billion. Just to maintain the same level of program activity in FY 1989 would require $29.7 billion. This concept of maintaining the same level of program activity as in FY 1988 is what we mean by "current services." The dollar increase from FY 1988 to FY 1989 needed to maintain current services (i.e., to maintain the FY 1987 level of services provided) is large - about five percent. Providing this increase is obligatory if the VA is to continue to provide the level of services in FY 1990 as was provided in FY 1989.

Unfortunately, as the table above shows, the FY 1989 enacted appropriations total about $500 million dollars less than the FY 1989 current services level (i.e., less than the amount necessary to continue to provide the FY 1988 level of services). We call for appropriation of the additional amount needed to reach the current services level in FY 1989 so that the VA can continue to provide the services it has offered in the past. If these additional funds are not appropriated, a considerable cutback in medical care, medical research, and in grants to states for extended care facilities will be required. Further, there will accrue an enormous backlog of applications for various veterans benefits that will not be processed for lack of staff.

In turn, the FY 1990 current services level is $31.3 billion, about $1.6 billion above the FY 1989 current services level. The $1.6 billion increase must be funded just to allow the VA to continue to operate in FY 1990 as it did in FY 1988.

As part of our computation of the current services level, we included amounts necessary to cover pay raises. We are recommending these amounts be appropriated in full, at the beginning of each fiscal year - not late and not partial, as has too often been the case in the past, resulting in staffing cuts and corresponding reductions in needed services for veterans.

Our total recommended VA Appropriation level for FY 1990 is $32.1 billion, about $800 million above the FY 1990 current services level. Thus, as is fitting in an era of fiscal austerity, most of the funding increase we recommend is required merely to cover increasing costs, not to support new initiatives.

Staffing

By far, the most serious problem facing the VA is a lack of adequate staff. The Reagan Administration's budget forces the absorption of an estimated $300 million from such items as unfunded salary and grade increases, arbitrary management and productivity "improvements" and the like. The end result of such cannibalization of resources is the loss of approximately 8,000 FTEE. Looking at employment figures in the budget, however, can lead to alternative conclusions. Reviewing staffing levels for all Medical Programs, including Medical Care, Research and MAMOE the actual reduction in employee levels is far greater.

Comparing funding levels called for in the FY 1989 appropriation with the number of FTEE the VA indicates it can carry this year with those funds and projected FY 1990 FTEE levels called for in the Reagan Administration budget, the total personnel reduction rises to a loss of over 17,500 FTEE.

FY 1989 FTEE Appropriation Level	200,028
FY 1990 FTEE Reagan Admin. Budget	190,435
Net Change	- 9,583
Less Forced Absorptions	- 8,000
Total FTEE Reduction	- 17,583

Funding For Prosthetics - Budget Line Item

Absorptions not only come out of staff, but out of other vital health care programs and services. PVA has long been concerned about intolerable delays in the provision of prosthetic equipment so vital to the daily living of our members and all disabled veterans. Funding for prosthetics, running the gamut from wheel chairs, leg braces to everyday medical equipment and supplies, is lumped into the general medical account allocation for each medical center. As unspecified funds, these dollars, already in short supply, have been used at the station level as available resources to "borrow" to cover shortfalls in other medical center accounts. As a result, prosthetic funding normally runs dry well before the end of each fiscal year. When this happens, veterans just have to go without; have to wait months for needed equipment; or are provided make-shift or substandard equipment as a result of chronic rationing.

PVA strongly recommends that funding for prosthetics should be a clear line item in Congressional Budget authorization and appropriations to identify how these funds are allocated and expended.

Reagan Administration Budget Analysis

The budget proposal would turn back the clock on any feasible plan to meet the long term care needs of the aging veteran population. The budget calls for a proposed reduction in Community Nursing Home Care - 3449 census reduction and 11,862 fewer patients treated. This is partially offset by increases in VA Nursing Home or State Nursing Home programs resulting in a net loss of 1575 census and 7983 patients treated. This reduction targets the older World War II veterans who have the greatest need of nursing home care.

- The VA Domiciliary Program is to be reduced by 2441 census (from 6445 to 4004) and by 6,371 patients treated. There is no proposal for the accommodation of these needy veterans who will be displaced.

- VA hospital inpatients treated will be reduced below the level for FY 1988 in spite of evidence which indicates that patients treated will increase substantially with the aging of the population.

- Outpatient care will be reduced to levels below those for FY 1988 in the face of an increasing demand for these services brought about by shifts from in-patient care to out-patient care and increases in chronic diseases that require monitoring in the aging veteran population.

- As in previous budgets, the Reagan Administration proposes a 1 percent "productivity" improvement that imposes a reduction of approximately 2000 health care personnel.

- Although it can be predicted that there will be a 4 percent cost-of-living adjustment for federal employees in FY 1990, funds to pay for this COLA are not in the budget proposal and will result in a shortfall of $200 million in FY 1990 - funds which, as in the past, must be absorbed from other health care resources.

- o Within grade increases were not included in the budget - an amount that is estimated to be in excess of $50 million which also must be absorbed from existing personnel costs.
- o No provision has been made for predictable increases in other employee benefits for FY 1990 e.g. health benefits).
- o Decentralized Hospital Computer Program initiatives in mental health are required to be offset by decreases of $27 million and 659 employees - in advance of demonstrated savings.
- o There is recognition of the important role of the VA in the treatment of AIDS patients where increases in funds and personnel for AIDS clinical programs are $55 million and 625 employees.
- o Education and training activities which are a part of the major mission of the VA are being curtailed - reductions are proposed as follows: -175 medical residents; -25 dental residents; -60 Psychology residents: -37 Administrative trainers; - 67 Instructional support personnel. There will be no increases in the opportunities for continuing education of VA staff.
- o The budget calls for legislative proposals designed to recover partial health care costs by requiring co-payments from certain category B and Category C patients as follows.
    - veterans will be required to pay $5(B) and $10 (C) for outpatient visits;
    - veterans will be required to pay $3 (B) and $5 (C) for prescriptions:
    - veterans will be required to pay $9 per day for hospital in-patient care (both B and C)

PVA was under the impression that the VA was planning to deny all health care to all Category B and C veterans, at many VA Medical Centers, making the savings from this legislative proposal somewhat illusory.

Medical and Prosthetic Research

The Reagan Administration budget reduces the appropriation request for medical and prosthetic research $13 million below FY 1989 and reduces employment by 615 FTEE. Funding for research initiatives to focus on the AIDS epidemic have received a substantial increase within this allocation. But these are not additional dollars, but a reapportionment of funds from other existing VA research dollars.

- o The entire reduction in research funding is proposed for investigator initiated research - the backbone of research in the VA. This will result in a reduction in new proposals that can be funded as well as a cut back in commitments to investigators who have on-going projects.
- o Health Services Research, which would help the VA improve and become more efficient in service delivery, receives no additional funding in FY 1990. This is, in reality a reduction.
- o Rehabilitation research - crucial to the care of veterans and their unique problems remains constant in FY 1990. In reality a reduction.
- o Since no cost of living adjustment is proposed for FY

1990, the likelihood is that any such increase would have to be absorbed, further reducing medical and prosthetic research capability.

Medical Administration and Miscellaneous Operating Expenses

- A further reduction of six employees will further inhibit the management capability for the Department of Medicine and Surgery.
- Since an employee cost of living adjustment in not proposed in the budget, further reductions in personnel can be anticipated at a time when the medical care program is being severely stressed.
- Health Professions Scholarships will increase by $653 thousand. These programs will support 310 nurses,and 40 physical therapists.

Department of Veterans Benefits

PVA is deeply concerned over the continued erosion in staffing within DVB. The Reagan Administration, in making these cuts, consistently argued the reductions are warranted due to reduced workloads and so-called "productivity initiatives" brought on by improvements in automation. Based on PVA's own on-site evaluation of the operation of the VA Regional Offices, we have found this to be absolutely untrue. The complexity and number of the cases currently pending at the Regional Office level have far overtaken the ability of DVB staff to process these claims effectively and in a timely fashion. We also have found it ludicrous for the Administration to cite management improvements and increased automation as rationale for reduced DVB staffing. Funding for DVB modernization has been totally inadequate to provide services and benefit delivery in an effective and timely manner.

A further reduction of 550 personnel would severely endanger the quality of claims processing and due process mandated by the Congress for the veteran population. In order to maintain current services, the Congress mandated that DVB maintain average employment of not less than 12,898 FTEE in FY 1989. The Reagan Administration has responded to that by recommending an average employment of 12,100 FTEE for FY 1990 - a decrease in 798 personnel from the Congressionally mandated level and a decrease of 550 personnel from the current estimated FTEE level of 12,650. Although this decrease includes the transfer of 227 FTEE whose mission has been primarily in support of DM&S, the Department of Veterans Benefits has, once again, been reduced by the Administration to a level far below that necessary to fulfill their Congressionally mandated mission. An analysis of the backlog of unworked compensation and pension cases is, perhaps, the most significant barometer of the state of affairs within DVB. As stated in the FY 1990 Independent Budget, this backlog has increased at an alarming rate from a total of 167,687 cases in October 1987 to a current total of 362,935 cases. According to VA projections, there will be a total of 683,451 unworked compensation and pension cases by October 1989.

Mr. Chairman, this totally unacceptable level of service is a direct result of inadequate appropriations for necessary staffing resources over the past decade. We call on you to reject the Reagan Administration's proposed reductions and restore appropriate FTEE levels to DVB.

Independent Budget

The FY 1990 Independent Budget recommends staffing levels and appropriations for each service within DVB. PVA believes these recommendations are a reasonable and realistic assessment of the current status of the General Operating Expenses and programmatic components of the Department. It is not our purpose today, therefore, to reiterate all of the concerns and recommendations expressed in the Independent Budget. Rather, we will highlight several of the areas we believe are most deserving of your attention and comment on the probable effects of the Reagan Administration's budget.

Veterans Services

With the exception of the ADP Systems Management Account which remains at 419 FTEE, every other service within the Department of Veterans Benefits will suffer staffing reductions under the former Administration's proposed budget. The Veterans Service Division (VSD) represents the front line of benefit delivery within DVB. Veterans Benefits Counselors assist with claims and provide information and advice to veterans, their dependents and survivors, and other interested parties. They conduct personal interviews and answer hundreds of thousands of telephone calls. This vital link to the veteran community, presently at its lowest FTEE level in twenty years, is now being asked by the Reagan Administration to accept one of the largest reductions of all DVB services - 91 FTEE.

Mr. Chairman, 1989 finds Veterans Services woefully undermanned. Coupled with the huge backlog of unworked compensation and pension cases, Veterans Services' inability to fulfill its mission of timely, efficient, and compassionate service has resulted in unacceptable service to our nation's veterans. Disadvantaged, homeless, and elderly beneficiaries will suffer the most from these insensitive staffing reductions.

Reduction In Loan Guaranty FTEE

PVA is deeply concerned that the Reagan Administration's FY 1990 budget calls for 45 fewer loan guaranty personnel. In addition to the demoralizing effects on over-worked employees, further cuts in FTEE will take a heavy toll on the program. At a time when Loan Guaranty is experiencing critical shortages of experienced staff to handle both record numbers of new guarantees and significant regional foreclosure problems, additional staff reductions will have a crippling effect on the ability of the program to even minimally carry out its mission.

Every effort should be made by VA staff to provide adequate counseling to avoid foreclosure on veterans' homes. Inadequate staffing levels prevent the VA from providing such assistance to individuals whose loans are heading toward default. This short-sighted budget formulation has resulted in an unnecessarily large number of foreclosures at great cost to the government.

Further staffing reductions will also result in the VA's inability to promptly process bids on VA-held foreclosed properties. This will inevitably result in the loss of potential sales to willing buyers. Such properties will then continue to be held by the VA at significant cost.

PVA strongly urges this Committee to reject further cuts in VA Home Loan Guaranty FTEE and restore funding to the General Operating Expenses for these desperately needed personnel. We believe that an FY 1989 supplemental appropriation to provide 140 additional FTEE's over the 1988 level is justifiably in order. We encourage your support for such an appropriation in order that the VA will have sufficient resources to address the numerous problems that currently besiege the program. The program cannot afford the loss of 45 FTEE.

Regarding the Loan Guaranty Revolving Fund, the Reagan Administration anticipates proceeds from recourse loan sales to be $910,800,000. Accordingly, an appropriation of only $453 million has been requested. This appropriation is completely inadequate to sustain the program. The Independent Budget recommends an appropriation equal to the former Administration's recommendation plus the amount the Administration expects to receive in recourse loan sales -- $1,363,800,000.

Vocational Rehabilitation and Counseling

Further reductions in the Vocational Rehabilitation Service, as recommended by the former Administration, will continue to erode the mission of this critical service. The rehabilitation of disabled veterans injured while on active duty provides an extremely beneficial service to both the individual and the nation as a whole. The proposed Reagan budget removes five more desperately needed personnel from this service. With an average workload of 182 cases (compared to a workload of 60 cases in the state/federal rehabilitation program), the typical Vocational Rehabilitation Specialist is understandably overwhelmed by the demands placed on his profession at the VA.

As a result of these demands, a service-disabled veteran must wait three months from the time he fills out the initial application until he has the initial interview with a counselor. Additional unacceptable delays occur during each subsequent phase of the rehabilitation process.

Budget constraints have eroded another important aspect of the Vocational Rehabilitation program. The service's ability to properly train their personnel has deteriorated significantly in recent years. Inadequate staffing, when coupled with inadequate or nonexistent training, has resulted in a totally unacceptable rate of incorrect decisions and determinations. We are encouraged by the Regional Training Seminars that have been conducted to improve the quality of services provided. We are hopeful that this vital effort is supported by an appropriate number of staff; otherwise, the progress to date will be seriously undermined.

Many veterans applying for vocational rehabilitation are able to complete the program by following a prescribed course of education or training followed by employment placement service. Many others, however, are in need of more comprehensive services including extended evaluation and periodic assessments by both VR&C and DM&S personnel. These two components must efficiently work together as a team in order to reach the ultimate goal of rehabilitating a disabled veteran. We have found that severe problems exist which significantly lessen the probability that such a goal will be achieved.

It is essential that the new Secretary take action to enable this benefit program to be delivered by a cohesive and united team, one with identical objectives, and one that can prioritize vocational rehabilitation within the spectrum of all benefit programs and medical activities.

Automated Data Processing

DVB's need to modernize in order to improve services to veterans while reducing costs is unparalleled in recent history. It will be only through the successful and complete implementation of automated data processing that the Administration will be rightfully able to declare, "we are doing more with less." The Reagan Administration has proposed funds of $52,747,000 and 419 FTEE for the ADP System Management Program in FY 1990. Without such funds, DVB will be forced to terminate its model station programs and will be forced to suspend other short and long term ADP programs. Although the Office of Management and Budget (OMB) had originally endorsed many such ADP programs, they did not provide the funds necessary for DVB to properly implement those activities in FY 1989. If past OMB actions continue to prevail, DVB will continue to lose essential FTEE, whether or not the modernization effort is successful.

DVB has developed several innovative and high profile programs that are in place and, in some cases, ready to go. Model stations, optical disk prototypes, and other technical enhancements will greatly improve the modernization effort by DVB. We are hopeful that the Committee will ensure that the ADP System Management Program receives this much needed and necessary appropriation.

Court of Veterans' Appeals (CVA)

The Reagan Administration Budget for 1990 includes $1,462,000 for the Court of Veterans' Appeals. This appropriation will support an average employment level of twenty, with a total of forty positions authorized.

Supplemental funds are also required prior to the President appointing members to the Court. The proposal for this appropriation calls for $1,205,000. Revised budget estimates may be submitted to the President by the Court and will be forwarded to the Congress without Executive Branch Review.

This proposed supplemental appropriation represents funds that will be needed for the initial start-up costs and operation of the Court. It will provide sufficient funding for the appointment of three Justices and one staff person for FY 1989.

Enactment of judicial review legislation and the establishment of the Court of Veterans Appeals was a major priority for PVA during the 100th Congress. We encourage this Committee to ensure the prompt implementation of this important legislation. While judicial review will present a challenge, it also provides a great opportunity for the protection and preservation of due process for all veterans seeking justice and accommodation from their government.

Cost of Living Adjustment

PVA continues to oppose any proposal that would index compensation benefits to the annual change in the Consumer Price Index. We firmly believe it is an attempt to undermine and bypass the responsible authority of Congress. The COLA has required Congressional action annually, a process which PVA continues to believe ensures Congressional control and results in greater flexibility and fairness in a fluctuating economic climate. Veterans are willing to shoulder their share of the burden of deficit reduction. We have consistently stated that we will accept a curtailed cost-of-living adjustment in veterans' benefits programs if all other federal program beneficiaries, including Social Security recipients, do so and there is a similar curtailment of federal contract cost increases due to COLAs in contractor employees' wages. Otherwise, we call for a full and equitable COLA increase in veterans' benefit programs.

Statement of

NOEL C. WOOSLEY

AMVETS National Service Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

On

THE PRESIDENT'S PROPOSED FISCAL YEAR 1990 VETERANS ADMINISTRATION BUDGET REQUEST
VS.
THE INDEPENDENT BUDGET PROPOSAL BY VETERANS FOR VETERANS

Tuesday, February 7, 1989

9:00 a.m., Room 334

Cannon House Office Building

Mr. Chairman, members of the committee, AMVETS thanks you for the opportunity to testify as one of the representatives involved in the independent budget proposal.

The attitude conveyed in the administration's proposed budget for FY 1990 does not portray a willingness to meet the challenge of adequately caring for those who served in America's military forces.

The budget request for FY 1990 calls for $28.6 billion to fund medical, compensation, and other programs to care for 27.3 million veterans, eligible members of their families, and survivors of deceased veterans. While this request is some $192 million greater than FY 1989 estimated requirements, it will once again fall short of what is needed in real dollars.

The 1989 budget provides $16.3 billion for benefit programs, $11 billion for medical programs and $488 million for construction. Total agency full-time equivalent employment is expected to be 213,143 - down 5,019 from that which is currently proposed for FY 1989. The VA claims that this loss will once again be absorbed by improvement in productivity, greater automation capabilities and a decreased case load. We have heard this before and yet the time it takes to process a beneficiary's claim continues to increase. AMVETS does not find it acceptable for the VA to modify its timeliness standards in an effort to meet timeliness requirements. In other words, the three months it took to process a claim in 1983, and meet timeliness requirements, now takes six months to process and yet is still considered timely. This is achieved by simply changing the timeliness standard.

The proposed "increase" in FY 1990 spending is laced with expenditures from non-appropriated VA trust funds and ill-advised legislative proposals that are short sighted and are not in the best interest of the VA or the nation's veterans. A good example is the proposed legislation, if enacted, would make the loan funding fee permanent and raise it from the current 1 percent to 3.8 percent, thus producing an estimated $534.3 million in revenues for the fund. The VA will also seek legislation to continue selling loans without recourse. In FY 1990, this would provide net proceeds of $535.2 million. AMVETS feels sure that the congress would never pass this type of detrimental legislation.

Another example is to introduce legislation to automatically index VA compensation payment to the annual change in the Consumer Price Index (CPI). This would guarantee full and timely cost-of-living adjustments to compensation beneficiaries, protecting them from the erosion of their benefits by inflation and the uncertainties of the current system of annually legislated COLAs. AMVETS, as it has in the past, remains opposed to the automatic indexing of compensation and DIC rates to the CPI. The special needs of many service-connected disabled veterans may not be equitably reflected in the general CPI.

When this budget is stripped clean, we see a funding proposal that is well-below zero growth for the VA and nowhere near meeting even the "current services" needs of the agency.

The bottom line is that the administration has again presented the veterans with a budget which falls far short of meeting the current and projected demands on the total VA system.

As you are aware, Mr. Chairman, AMVETS, the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars have once again cooperated in an effort to address the needs of America's veterans -- needs based on moral as well as legal obligations this nation has to those men and women who answered duty's call. Thus, for the third consecutive year we, who are veterans, have produced an independent budget by veterans, for veterans. With the knowledge that each member of this committee has a copy of that proposed budget, I wish to point out that AMVETS totally supports the principles and guidelines used in its formulation (see page 13). We further view the independent budget in total as a legitimate alternative to the administration's proposed FY 1990 budget, which overall is not only inadequate and unrealistic, but is perhaps, the final betrayal.

AMVETS, as a member of this panel, will be commenting on that portion of the independent budget that pertaining to the National Cemetery System (formerly the Department of Memorial Affairs.)

The veterans service organizations (VSO) believe that this component is doing a good job in meeting current needs. In fact, in preparing the independent budget, it was refreshing to read the budget justification from the Department of Memorial Affairs. The FY 1989 budget justification for this account is a good example of responsible budget formulation. Current and projected workload trends affecting resource needs were discussed and it was recommended that there be at least a slight increase in full-time-equivalent employees (FTEEs), in addition to continuing the trend toward increased efficiency, to maintain adequate service in the face of a growing workload. The VSOs believe that the Administration's FY 1990 budget request for 35 additional FTEEs at a cost of $3.2 million is adequate for this well-run department **to meet the short-term needs of veterans**. Based on information supplied by the Veterans' Administration (VA), the following facts however, are directly relevant to long-term budget needs:

- There are currently more than 1.1 million veterans who are 75 years of age and older. Current estimates show 126,000 World War I (WWI) veterans with a median age of 91 and 9,606,000 World War II (WWII) veterans with a median age of 66.

- The states listed below have no national cemetery or have one that is currently closed to new interments:

NO CEMETERIES

Connecticut
Delaware
Idaho
Montana
Nevada
New Hampshire
District of Columbia
North Dakota
Rhode Island
Utah
Vermont
Washington
Wyoming

CLOSED

Arizona
Georgia
Maine
Maryland
New Jersey

(NOTE: The VA states that most closed national cemeteries can inter cremated remains.)

* Through 1989, 51 of the 112 operating national cemeteries will be closed to new interments.

* Nineteen states will have no national cemetery or have cemeteries closed to new interments.

* From 1990 to 1994, 2 new cemeteries will open, but an additional 10 cemeteries will be closed, and by the turn of the century, 8 more will close.

* In other words, by the year 2000, based on current DVA projections, only 45 national cemeteries will be open for new interments.

These facts are disturbing to the VSOs in view of the aging veteran population and the obvious need for a greatly increased number of gravesites in the National Cemetery System in the not too distant future. In this regard, the VSOs would like to see at least one open cemetery in each state.

The need is clear, as is the reality, that planning for and acquisition of gravesites cannot be done overnight, nor can it be done without funding.

The planning, funding, and acquisition of additional gravesites should begin now and the resources needed to do this should be reflected in the DVA's budget.

Finally, the VSOs recommend an appropriation of $6 million for grants for the construction of state cemeteries for FY 1990. This amount was the projected in the administration's FY 1989 budget submission. We note, however, that in the FY 1990 administration budget an appropriation of $4.4 million is now being requested which, in the view of the VSOs, is yet another example of short-sighted budget practices. Compounding the problem is the fact that projections for grant amounts in the out years through 1993 have been reduced without any indication of diminished need.

In closing, let me reiterate AMVETS support of the independent budget by veterans for veterans' programs and request that it be made part of the record of these proceedings.

This concludes my remarks and I thank you.

STATEMENT OF

HONORABLE JOHN PAUL HAMMERSCHMIDT

COMMITTEE ON VETERANS' AFFAIRS

Thank You, Mr.Chairman.

I am pleased to see the mantle of leadership on this side on the aisle pass to Bob Stump. He is a good friend and respected by his collegues. I congratulate him on assuming the important responsibilities of Ranking member of the full Committee.

Mr.Chairman, last week we heard the Hospitals and Health Care Subcommittee hearing on the Veterans' Subcommittee Construction budget, and the stage was set for this morning's hearing, I'm afraid. Right now, there appears to be little doubt that the budget the VA has proposed for fiscal year 1990 does not have a happy ending for veterans.

It seems obvious that the proposed funding for VA personnel will not support the levels of employment it says it will. It also seems obvious that the proposed funding for the Department of Veterans' Benefits means slower claims processing for hard-pressed veterans. It is further obvious that the proposed funding for the Department of Medicine and

Sugery will not move the VA toward improved long-term care for our aging veteran population. But what is not obvious in this proposed budget is how it would enable the Government to live up to its responsibilities to veterans.

Mr. Chairman, I hope that after the two days of hearings, we will have developed a clearer view of the funding levels needed to avoid the demise of the VA. The Acting Administrator and the department heads, who came here with unenviable task of defending the indefensible, have been before this Committee many times in years past. They are honorable men who have years of dedicated service to veterans. I want them to understand we know that, because we will be asking hard questions.

Mr. Chairman, there is much to cover, so I'll conclude my remarks with the observation that our work is certaintly cut out for us in persuading the Budget and Appropriations Committee, and the new Administration that the VA budget is going to need substantial enhancements just to return to the current services level of the last fiscal year. Today's hearing should certainly help us with our case.

Thank You Mr, Chairman.

HONORABLE CHRIS SMITH, NJ
OPENING COMMENTS ON VETERANS' AFFAIRS FULL COMMITTEE HEARING ON FISCAL YEAR 1990 VA BUDGET REQUEST
FEBRUARY 7, 1989

Thank you Mr. Chairman.

Mr. Chairman, thank you for setting up these two days of hearings to discuss the fiscal year 1990 VA budget request.

As the Ranking Minority Member of the Subcommittee on Education, Training, and Employment, I am particularly concerned with the FTEE reductions in the Vocational Rehabilitation and Counseling Service (VR&C) as proposed in the budget request. Over the past four years, there has been a steady decline in VR&C FTEEs and at the same time, an increasing workload for existing counselors and vocational rehabilitation specialists. Consequently, veterans seeking assistance in rehabilitation or job counseling are waiting approximately three months to receive an initial evaluation.

It is painfully clear that the funding for the Veterans' Health Services and Research Administration is inadequate. As our Committee found just last September, a funding shortfall exists in FY '89 which is seriously affecting the delivery of care in VA medical centers. If we do not resolve this inadequacy now, we will merely shift the funding dilema and the problems it creates, to the next fiscal year. Considering the inadequacy of the FY 1990 budget request, we cannot rely on FY 1990 funds to ease this financial pinch.

Veterans are a priority in this country and we need to treat them accordingly. The existing budget request does not accomodate the level of services veterans deserve-- it does not even meet the rate of inflation or the rise in the medical consumer price index.

Mr. Chairman, I look forward to hearing the testimonies of Mr. Harvey and representatives from the veterans organizations who have worked so ardently in preparing their independent budget request.

STATEMENT OF THE HONORABLE MICHAEL BILIRAKIS

MR. CHAIRMAN, THANK YOU FOR CALLING THIS HEARING IN ORDER TO DISCUSS THE PROPOSED BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 1990.

IN ALL HONESTY, I MUST VOICE MY CONCERNS OVER THE DRASTIC SHORTCOMINGS IN PROPOSED BUDGET AND SPECIFICALLY IN THE PROPOSED MEDICAL CONSTRUCTION BUDGET. EVERY YEAR, THE VETERANS ADMINISTRATION PROPOSES, AND THE OFFICE OF MANAGEMENT AND BUDGET SLASHES. FOR THIS FISCAL YEAR, THE V.A. REQUESTED FUNDING FOR THE 120 BED NURSING HOME IN LAKE CITY, FLORIDA, AND OMB REJECTED FUNDING FOR THIS MUCH-NEEDED FACILITY. FUNDING FOR THE PROPOSED 290-BED LONG-TERM PSYCHIATRIC FACILITY IN GAINESVILLE, FLORIDA FOR WHICH I APPLAUD THE VETERANS ADMINISTRATION'S REQUEST, WAS ALSO REJECTED BY OMB. IN ADDITION, I MUST ASK, WHAT HAS HAPPENED TO THE SLATED HOSPITAL FOR EAST CENTRAL, FLORIDA? I MUST SAY THAT MARCH 15, 1989, THE EFFECTIVE DATE FOR THE ESTABLISHMENT OF THE DEPARTMENT OF VETERANS AFFAIRS, WILL NOT COME SOON ENOUGH IN THIS MEMBER'S OPINION. ONCE A CABINET LEVEL DEPARTMENT, SECRETARY-DESIGNATE, EDWARD DERWINSKI, WILL ADVOCATE FOR AMERICA'S VETERANS AND CHALLENGE OMB'S ARBITRARY BUDGET CUTS.

THE VETERANS ADMINISTRATION REQUESTED APPROXIMATELY $950 MILLION FOR THE UPCOMING FISCAL YEAR FOR THE MEDICAL CONSTRUCTION BUDGET BUT OMB SLASHED THAT REQUEST IN HALF. THIS IS OF DEEP CONCERN TO ME IN LIGHT OF THE RECENT VA CAPITAL FACILITIES STUDY (CFS). THAT STUDY ESTIMATES THAT $1.45 BILLION IN CONSTRUCTION COSTS WOULD BE REQUIRED TO CORRECT THE DEFICIENCIES IN THE FACILITIES NATIONWIDE. I DO NOT NEED TO EMPHASIZE THE OBVIOUS FACT THAT THE DETERIORATION OF VA FACILITIES HAS A PROFOUND AFFECT ON THE QUALITY OF HEALTH CARE DELIVERY TO VETERANS. THE DECREASE IN FUNDING FOR THE MEDICAL CONSTRUCTION BUDGET AND SPECIFICALLY THE $41.5 MILLION DECREASE IN FUNDING FOR NURSING HOMES ARE TROUBLESOME IN VIEW OF THE CAPITAL FACILITIES STUDY.

THE NEED FOR NEW CONSTRUCTION AND REPLACEMENT FACILITIES IS MOST APPARENT IN THE STATE OF FLORIDA WHERE 1.5 MILLION VETERANS RESIDE. 15,000 VETERANS MOVE PERMANENTLY TO FLORIDA EVERY YEAR. THIS IS A GREATER GROWTH RATE IN VETERAN POPULATION THAN ANY OTHER STATE IN THE COUNTRY. THE GROWING NUMBER OF AGING VETERANS IN FLORIDA ALSO POSES A PARTICULAR HEALTH CARE PROBLEM FOR THE VETERANS ADMINISTRATION AND ONE WHICH MUST BE RESOLVED IMMEDIATELY. NINE PROJECTS IN FLORIDA WHICH WERE SLATED BY THE VA FOR INITIATION IN FY90 AT A COST OF $282 MILLION WERE POSTPONED.

IT IS WELL KNOWN BY MEMBERS OF THIS COMMITTEE THAT I FEEL THE VA BUDGET HAS BEEN A VICTIM OF SHORTSIGHTED BUDGET CUTS. I CERTAINLY DO NOT BELIEVE IT IS ACCEPTABLE TO BALANCE THE FEDERAL BUDGET ON THE BACKS OF VETERANS, NOR DO THE MAJORITY OF MY COLLEAGUES. WE MUST BE CAUTIOUS IN THE ALLOCATION OF VA RESOURCES AND PROVIDE VA SERVICES AND BENEFITS WITHIN THE BEST OF OUR ABILITY.

WITH REGARD TO THE OVERALL VA BUDGET FOR FY90, THE ADMINISTRATION'S BUDGET REQUESTS $28.6 BILLION IN APPROPRIATIONS FOR EXISTING PROGRAMS. THIS WILL NOT PROVIDE ADEQUATE FUNDING FOR CURRENT SERVICES. AS WE ALL KNOW, CURRENT FUNDING IS INSUFFICIENT THE SYSTEM IS PLAGUED WITH STAFF SHORTAGES, TERMINATED SERVICES AND OTHER PROBLEMS WHICH HAVE LED TO THE TURNING AWAY OF VETERANS. IT IS PREDICTED THAT THE VA WILL SUFFER A $1 BILLION SHORTFALL IN FISCAL YEAR 1990.

I ALSO HAVE CONCERNS REGARDING THE PROPOSAL TO CHARGE 0% TO 20% SERVICE-CONNECTED DISABLED VETERANS FOR NONSERVICE-CONNECTED HEALTH CARE, AND (1) TO HAVE NONSERVICE-CONNECTED VETERANS IN HIGHER INCOMES AND (2) THOSE CATEGORY C PENSION VETERANS IN HIGHER INCOMES PAY COPAYMENTS.

IN CLOSING, I WISH TO TOUCH UPON A POSITIVE BUDGET PROPOSAL -- THAT BEING THE $112 MILLION FACILITY AT PALM BEACH, FLORIDA. THIS FACILITY IS LONG OVERDUE AND I AM PLEASED THE VA REQUESTED ITS FUNDING.

THANK YOU MR. CHAIRMAN.

MIKE SYNAR
2d District, Oklahoma

Committees
ENERGY AND COMMERCE

JUDICIARY

GOVERNMENT OPERATIONS

SELECT COMMITTEE
ON AGING

Congress of the United States
House of Representatives
Washington, DC 20515

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TESTIMONY SUBMITTED TO THE HOUSE COMMITTEE ON VETERANS AFFAIRS
VA BUDGET FOR FISCAL 1990
Mike Synar, M.C.
February 7, 1989

Mr. Chairman:

I share your concern about the Administration's proposed spending plan for veterans' programs for fiscal year 1990, which would cut nearly 9,000 VA health care employees, reduce medical facility construction, and deny medical care to thousands of veterans.

I am submitting testimony on behalf of the 150,000 veterans in the area of jurisdiction served by the VA Medical Center in Muskogee, Oklahoma, which has served the veterans of my Congressional district for over sixty years.

Given the reduction of services at our Medical Center already required in fiscal '89, further cutbacks would have a devastating effect on the morale of employees and the veterans served by the Center. For your information, I have submitted a copy (attached) of a survey of the Medical Center conducted by a Senior Field Representative of the Veterans of Foreign Wars. You will note that although the Medical Center has an authorized bed capacity of 230, 57 are currently out of service. Two wards have been closed due to staffing shortages. This reduction in patient services and staff has dealt an alarming blow to the veterans of Oklahoma.

Clearly, the VA medical system now faces serious problems in its ability to maintain quality care and to provide timely access to care for all entitled/eligible veterans.

The Administration's budget is grossly inadequate to carry out this task. In response to the President's proposal, Congress must present a budget which will enable the Veterans Administration to fulfill its statutory obligations. I am confident that the Committee's proposal to the Budget Committee will provide a more satisfactory proposal for funding veterans' medical programs.

As this committee considers the VA budget for fiscal 1990, I would encourage you to consider the following recommendations:

1) Changes in the budget for the VA health care system should be based upon changes in the VA user population and on workload projections for the system that are based on current experience, past trends, and anticipated changes in the modalities of health care delivery.

Testimony before House Committee on Veterans Affairs
February 7, 1989

2) VA patients should have available to them a sufficient quantity and balance of the various types of levels of medical care to promote maximum efficiency in the use of resources in the VA medical system.

3) The inflation index for increments in the VA medical care budget should reflect increases in health care industry cost indices.

4) VA staffing shortages are seriously restricting access to and quality of services provided. The pay scale for physicians, nurses, other medical personnel, employees and support staff should be adjusted in order to compete with other public and private health centers. The scale used by similarly situated Health Maintenance Organizations may be helpful in providing such guidelines.

5) Within every VA medical facility, the integrity of the clinical team involved in direct patient care should be maintained, with VA management and staffing of the team. Only industrial-type services should be considered for contracting out, and then only if cost savings can be achieved.

6) Greater attention must be given to the interaction between the VA health care system and other health care systems in the United States, including the impact on the VA of reductions in Medicare and Medicaid funding and increases in co-payments. Veterans who are unable to meet increasing Medicare copayments are looking to the VA as a safety net.

Mr. Chairman, thank you for the opportunity to submit testimony to the Committee. I want to assure you that I stand ready to support your efforts to maintain an adequate level of funding for veterans health care, the travel allowance for patients, and medical facility renovation and construction. Meeting the needs of aging veterans and maintaining access to quality care for all eligible veterans are the major challenges confronting the VA's medical care program. We are counting on you, as an advocate for veterans throughout the nation, to offer a budget proposal which will enable the Veterans Administration to rise up to that challenge.

***

STATEMENT BY CONGRESSMAN L. F. PAYNE, JR.

COMMITTEE ON VETERANS AFFAIRS

February 7, 1989

MR. CHAIRMAN, I very much appreciate the effort and input by Mr. Harvey on behalf of the Veterans Administration, as well as the Independent Budget by Veterans for Veterans Programs improving FY 1990 budgets. The testimony today will be extremely helpful to me and other members of this Committee as we deal with some hard decisions to reduce the budget deficit in FY 1990.

I am deeply concerned about this budget and what is says about quality health care for my fellow veterans. Since 1980, we have seen the demand for health care services increase substantially. Inpatient care has risen from 1.0 million patient visits to 1.1 million while outpatient visits has risen from 16 million to 21.5 million. At the same time, health care expenditures, adjusted for inflation, have increased by only about 2-3% or $400 million in the same period.

It is said that "a promise made is a debt unpaid." We must fully pay our "debt" to our veterans, which is adequate and timely health care. It is indeed one of the most important obligations of this nation, not only for the past but future national defense.

Having reviewed the material, I have concluded that the budget proposed by the VA simply is not providing sufficient resources to fulfill the health care mission for our veterans.

I look forward to working with you, Mr. Chairman, and my colleagues in correcting this matter of such importance to our veterans and our nation.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE FY '90 VETERANS ADMINISTRATION BUDGET

WASHINGTON, D. C.

FEBRUARY 7, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to appear before this distinguished Committee to present the views of the Veterans of Foreign Wars with respect to the Administration's fiscal year 1990 budget proposal for the Veterans Administration. The VFW is appreciative of this Committee for holding this hearing and demonstrating its continuing concern for our nation's veterans.

Once again, the Veterans of Foreign Wars is proud to have joined AMVETS, Disabled American Veterans and Paralyzed Veterans of America in presenting to the Congress an independent budget for the Veterans Administration. As the name implies, our proposal is independent of the Office of Management and Budget's (OMB's) influence and is based solely on what we perceive as the minimum requirements for the Veterans Administration to provide the necessary benefits and entitlements our veterans have earned. Before addressing the construction aspect of the Administration's proposal as compared to the Independent Budget, I would like to make several comments addressing the VFW's evaluation of the overall FY '90 VA budget.

On January 9, 1989, then President Ronald Reagan unveiled a $29.9 billion FY '90 budget for the Veterans Administration. This budget, while showing a slight increase of $192 million over last year's, still falls way short of meeting the needs of veterans. Even though medical care is increased by almost $200 million, when one takes into account inflation and the fact the VA's Department of Medicine and Surgery is experiencing an estimated shortfall of approximately $700 million for the current fiscal year, the VA will be hard pressed to meet its mandated and moral obligations.

As was the case last year, the Administration's FY '90 budget is an excerise in deception. While boasting of the largest VA funding level in history, the Administration has presented to Congress a VA budget that is inflated with a $900 million expenditure for VA managed trust funds which, in fact, do not require appropriations. Furthermore, another $900 million is included in the budget for proposed legislation calling for "credit reform." This plan is nothinig more than a scheme whereby the Congress will be required to appropriate money equal to the estimated subsidy value (the additional amount OMB claims a VA loan is worth to an individual) of the loans it makes or guarantees. The Congress rejected this plan last year and we do not foresee their wise decision being reversed this year. When one also takes into consideration other legislative proposals which stand little chance of passage, it becomes painfully clear the Administration's proposal falls significantly short of the dollars it professes to provide the VA.

Mr. Chairman, the Administration also proposes to cut the number of full-time medical and research employees by 8,957. At a time when veterans are being turned away from VA medical facilities and entire wards are being shut down due to staffing shortages, we can only interpret this action as a blatant attempt to undermine the entire VA health-care system. Likewise, the Department of Veterans Benefits (DVB), which is responsible for the adjudication of claims for compensation, pension and education benefits as well as home loan guaranties and burial benefits, is $30 million short of a current services level. If the Administration's recommended funding level is adopted, DVB's employment level would be reduced 6% in spite of the fact that since 1979 more than one-third of the DVB's workforce has been eliminated. Of course, this has resulted in the deteriorating of timeliness, effectiveness and overall quality of service to veterans.

Mr. Chairman, this overview serves to voice the VFW's rejection of the Administration's budget proposal. We, of course, will provide detailed analysis of the Administration's funding and legislative proposals for specific programs at the upcoming subcommittee hearings. At this time, I will direct my testimony to the Independent Budget recommendations as it pertains to the VA's construction program.

The Veterans of Foreign Wars recommends a $922 million construction program appropriation for FY 1990. Our total sum is almost twice the $488 million reflected in the President's FY 1990 Department of Veterans Affairs budget submitted January, 1989. We believe about $635 million should be used for major construction and $275 million be used for minor construction with $12 million earmarked for the relatively new Revolving Fund Parking Garage Program.

The major portion of our major construction appropriation recommends $559 million should be used as stated in the Veterans Administration's construction requirements cited in their own "Five Year Medical Facility Development Plan for FY 1990", published in August 1988. We strongly believe much more monies should be available this year for the rehabilitation center and canteen at the Salt Lake City, Utah Medical Center; that there is still a valid requirement for the clinical addition to the Wilmington, Delaware Medical Center and a new psychiatric building in Columbia, South Carolina's Medical Center as well as the need to repair and otherwise correct the structural seismic deficiencies at the Long Beach, California Medical Center. As previously stated, these and other medical center construction projects were considered as a high priority by the VA as recently as seven months ago. We also hasten to add that lacking an in-depth analysis of national construction requirements, that these funds should be dedicated for FY 1990 in view of the very lengthy time involved in the current building replacement and/or improvement cycle, the changing clinical requirements, and the age of the current plant in general.

The next largest recommended appropriation is $40 million for the Advance Planning Fund and Design Fund. The purpose of these two closely related funds is to allow projects to proceed in an expeditious and cost effective manner through the planning and design stages of the construction process. This represents some $15 million more than the approximate $25 million the VA has requested. We believe ours is a more rational figure to begin to accelerate the historically lethargic ten year construction process. This strategy of a strong early effort for planning and design at the beginning of the construction "pipeline" will support and accelerate rapid expansion of the overall volume of needed major construction projects once the VA's process for national construction prioritization has been developed, and also when greater sums of money can be forthcoming from the Congress. For the real cost just begins with the pouring of cement and continues through to the equipping and furnishing of the structure itself.

Our next major construction program deals with nursing homes. This is a very significant item and we believe $30 million is the absolute minimum required to fund four new facilities of 120 beds each. As you recall, the primary mission of nursing home facilities is to provide care to veterans who have chronic conditions requiring care but who are not in need of hospital treatment. We believe the expanding segment of the "old-old" veteran population, those 75 and older, will require such facilities. Accordingly, we can foresee a need to build four new VA nursing homes each year for the next several years of this coming decade. This must be done in conjunction with the earlier request of the Veterans of Foreign Wars to have the VA convert 1,000 existing hospital beds to nursing home use each and every year through the 1990s starting with a one-time conversion of about 2,000 such beds to this purpose beginning in FY 1990 which will start on October 1, 1989. Based on the above discussion of the lack of nursing home facilities, we believe the VA's requested $2 million for FY 1990 is woefully inadequate.

Our last major construction appropriation is for $6 million to be spent for purchase of land for new national cemeteries in the eight states that have absolutely no national cemetery facility. They are Idaho, Montana, Nevada, New Hampshire, North Dakota, Vermont, Washington and Wyoming. We believe the VA should budget enough money each of the next four years to add two new national cemeteries annually until the National Cemetery System has met our minimum goal for having available grave site space in every state. Our eventual goal is to have a usable national cemetery within reasonable distance of each of the nation's major veteran population centers.

A primary intent of the $275 million of minor construction monies is to ensure that the entire VA system is maintained in a good state of repair. Tasks range from moderizing the functional space in a regional office to renovating facilities in health care delivery rooms to accommodate technologically advanced equipment.

Of this above total, $200 million is identified for medical construction minor projects, with $40 million specifically set-aside for the conversion of existing medical center space to nursing home use exclusively. This estimated $40 million should be sufficient to permit the conversion of the previously mentioned 2,000 bed spaces to nursing home care in this fiscal year. The reason for this one-time conversion of 2,000 bed spaces is to reinforce our concern that the 1,000 bed conversion recommended in the FY 1989 IB was, in fact, not accomplished. As you recall in our discussion of major construction, it is our judgment that to convert about 1,000 VA hospital beds to nursing home use each year for the next seven to nine years is imperative. This is one significant area of professional difference wherein we believe the future has been badly underrepresented in the VA budgetary process for the past few years. This set-aside of at least $20 million annually for conversion, with the FY 1990 $40 million, is an attempt to resolve the VA's past argument that it was a lack of construction funds that prevented their initiation of this needed bed conversion project. In concluding our case for beginning to establish an adequate national nursing home care program for our nation's veterans, we hold that any rationale to turn this effort over to the various states as had been mentioned, creates the reductio ad absurdum of requiring states to provide for their own military defense. This issue was resolved over 200 years ago when our Constitution was ratified. In fact, this criticism highlights the importance the VFW places on the matching grant programs extended to the respective states through the VA to ensure a uniformly high degree of excellence within the nursing home field. Therefore, the VA's requested $2 million for minor construction projects for nursing home care should be an area of real concern to be resolved this year.

We propose to almost double the funds needed this year for reasonable amounts of money required to support priority minor construction projects in the VA's Regional Offices (VAROs) and in existing National Cemeteries. This rationale is supported in our FY 1990 IB projections of $5 million and $10 million respectively for VAROs and cemeteries. To do any less regarding office buildings that are an average of about 40 years old is to be "penny-wise and pound-foolish". Or said another way, in the short run it will cost more money just to maintain the present state of obsolesce and shabbiness.

The last appropriation of $60 million in minor construction funds is to be spent for that portion of the VA staff that oversees the entire construction process; primarily, the Office of Facilities. Our overriding concern is to maintain the Office of Facilities at least at current manning levels and to allow the VA to take steps to initiate now a formal institutional process that will define construction priorities in terms of nationwide construction strategy. In point of fact, the Veterans Administration had commissioned several major studies to examine its current construction process. We accept this initial action, but we believe it is now time to address the systemic problems that have been identified. The most obvious one being the excessive time required to complete construction projects. Appendix D of the FY 1990 IB is devoted exclusively to the recognized problems in the VA's construction program philosophy.

Last, we propose $12 million be appropriated for the Parking Garage Revolving Fund. This is some $5 million greater than the $7 million the VA has asked for in new budget authority for Palm Beach, Florida. We recognize the Parking Garage

Revolving Fund is a relatively recently established appropriation. When the fund is fully established, revenues from the parking garages which it has financed will at least partially pay for needed additional parking facility projects. Because this particular fund is in a start-up mode, and because reasonable access to medical treatment is an essential element of the treatment process itself, especially with an aging veteran population, we believe it is essential to "prime the pump" now to start the revolving fund flowing and to provide the needed parking.

Mr. Chairman, this concludes my testimony and I will be happy to respond to any questions you may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

COPY

January 17, 1989

John A. Gronvall, M.D.
Chief Medical Director (10)
Department of Medicine & Surgery
Veterans Administration Medical Center
810 Vermont Avenue, N.W.
Washington, DC 20420

Dear Doctor Gronvall:

I am forwarding herewith a copy of report of survey of the Muskogee, Oklahoma, Veterans Administration Medical Center, conducted by Mr. Robert F. O'Toole, Senior Field Representative, of our staff.

You are advised that the Medical Center Director is being furnished a copy of this report.

A response at your convenience will be appreciated.

Sincerely,

Cooper T. Holt

COOPER T. HOLT
Executive Director

Enclosures

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VETERANS ADMINISTRATION MEDICAL CENTER

STATISTICAL SHEET

DATE September 12, 1988

LOCATION VA Medical Center, Muskogee, Okla.

CLASSIFICATION

MEDICAL SCHOOL AFFILIATION

DIRECTOR Tom Mason

CHIEF OF STAFF Gayle Harris, M.D.

AUTHORIZED BED CAPACITY 230

OPERATING BEDS 173
OUT OF SERVICE 57

PLANNED ADC, CURRENT FY 140

CUMULATIVE ADC TO DATE 132

CUMULATIVE ADC, ONE YEAR AGO 135

TOTAL PATIENTS TREATED (CUMULATIVE):
INPATIENT LAST FY 5003
INPATIENT TO DATE CURRENT FY 4106
NON-VETERAN PATIENTS TREATED FY TO DATE

BED OCCUPANCY RATE (CUMULATIVE) 74.8

PATIENT TURNOVER (CUMULATIVE) 301

AVERAGE LENGTH PATIENT STAY 9

APPLICATIONS PENDING 0

NSC WAITING LIST (CURRENT) 0
(ONE YEAR AGO) 0

SCHEDULED FOR ADMISSION 49

ACCEPTANCE RATE (CUMULATIVE)

VETERAN POPULATION AREA OF JURISDICTION 151,437

FIELD REPRESENTATIVE Robert F. O'Toole

FULL-TIME EMPLOYEE EQUIVALENT
TOTAL ON BOARD 627.1

STAFF PHYSICIANS 26.4

PART-TIME PHYSICIANS 2.8

CONSULTANTS 47
CONSULTANTS VISITS LAST QTR 115

DENTISTS 4.0

RESIDENTS

REGISTERED NURSES 103.7

LICENSED PRACTICAL NURSES 21.5

NURSING ASSISTANTS 18.9

PART-TIME RN'S 8 LPN'S 1 NA'S 0

BUILDING MANAGEMENT EMPLOYEES 36.9

ADMINISTRATIVE EMPLOYEES 159.8

STAFFING RATIO (SPECIFY CORE, ETC.):
CURRENT FY
PREVIOUS FY

TOTAL OPERATING BUDGET:
CURRENT FY $ 38,861,406
PREVIOUS FY $ 38,132,449

RESEARCH BUDGET:
CURRENT FY $ 1,527
PREVIOUS FY $ 6,274

MAJOR CONSTRUCTION:
FUNDED CURRENT FY $

COST PER PATIENT DAY $ 370.14

OUTPATIENT CLINIC 8-22-88

STAFF VISITS:
FY TO DATE 124,509
FUNDED FOR FY
PREVIOUS FY 120,368
FUNDED FOR PREVIOUS FY

PATIENTS THIS DATE:
OPT-SC 59,730
OPT-NSC 54,342
C&P EXAMS FY TO DATE 2,510
PREVIOUS FY 2,503

INCLUDE STATISTICS FOR DOMICILIARY AND NURSING HOME CARE UNIT (NHCU) WHERE APPLICABLE.

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VETERANS ADMINISTRATION MEDICAL CENTER
MUSKOGEE, OKLAHOMA

September 12-16, 1988

1. INTRODUCTORY REMARKS:

This hospital was built by the state of Oklahoma as a gift to the nation's veterans in 1923. In March 1925, the Veterans Bureau purchased the building along with the city hospital next door. The two buildings were connected in 1937 by a two-story wing. An additional story was added in 1957 to house the surgical suite. The other major changes that have occurred were the completion of the clinical addition in 1985 and the chapel in 1988.

The medical center has an authorized bed capacity of 230 with 57 currently being out of service. This is mostly due to staffing shortages in residents, physicians and nurses. This subject will be covered in the next paragraph.

Muskogee VA Medical Center is in the Southwestern Region and Medical District 19, which includes VA Medical Centers in Oklahoma City, Oklahoma; Little Rock and Fayetteville, Arkansas, along with New Orleans, Alexandria and Shreveport, Louisiana. Muskogee operates a satellite clinic in Tulsa, about 50 miles northwest of the hospital. Under the Medical District Initiated Program Planning (MEDIPP) process, the medical center has opened a new outpatient clinic in Tahlequah, Oklahoma, and has requested an additional clinic at Claremore, Oklahoma. The hospital has plans under review in Central Office for a new 210-bed tower which will include a replacement surgical suite.

2. CONFERENCE WITH DIRECTOR AND CHIEF OF STAFF:

The current budget of just under $39 million for FY-88 is about $2.2 million less than they started with in October. This reduction has caused the medical center to reduce their FTEE from 693 to 623 employees. This staffing level is not adequate to continue to provide quality health care to the veterans of eastern Oklahoma. The cost of the beneficiary travel program is double the amount budgeted.

The Muskogee VA Medical Center is currently affiliated with the University of Oklahoma's Tulsa Medical College. The medical school utilizes three medical centers, including the VA, to rotate their residents. For academic year 88-89, the school was unable to attract a sufficient number of general internal medicine residents to their program. Rather than sharing the shortfall with the other medical centers, the VA was informed that no general internal medicine residents would rotate through Muskogee.

Through negotiations, the VA now is to receive 15 residents, equating to 10.66 FTEE, from the Tulsa Medical College. The medical center has had to close beds, transfer patients to other VA medical centers in their district and cancel as many appointments as possible to cope with this shortfall. Adding to the problems of this medical center is the difficulty in recruiting registered nurses. With the loss of residents and the lack of trust in the medical school leadership, many full-time staff physicians are looking for new employment. Their stated primary interest is in teaching new doctors rather than cover wards on a 24-hour basis. Hopefully, this situation will be cleared up before the medical center loses its ability to perform their main mission of providing primary and secondary health care to the estimated 150,000 veterans residing in their primary service area.

Currently, the medical center has one vacancy on the professional staff, that is for a Chief of their Geriatric Evaluation Unit. It was estimated that an additional three physicians would be needed for inpatient care, two for the outpatient area, as well as two surgeons to make up for the lack of residents.

The medical center received a CAT scan which was the first of the year. So far, it is meeting the needs of the hospital, although it was opined that the scan would not live up to the manufacturers claims. As with other older medical centers, this one is facing problems maintaining the desired level of patient privacy and quality of care. With very few private rooms available, and then not always on proper wards, it is hard to maintain privacy for female patients as well as isolation when required. The lack of wash basins in patients' rooms leads to time being wasted by physicians and nurses having to leave the room to wash their hands. Given this situation, I am sure that hands do not get washed as often as they should. Very few patient rooms have piped-in gases or suction. This requires the use of portable equipment which is both dangerous and labor intensive. The small rooms on the wards are also overcrowded when this portable equipment is utilized. The new 210-bed tower will hopefully correct these deficiencies when completed. The Veterans of Foreign Wars supports the plan referred to as 3-Consolidated. It is estimated to cost $3 million more to construct, but would save $16 million overall. This does not, of course, take into consideration the time that would be saved over the years by both staff and patients if this plan is used.

3. MEDICAL SERVICE:

This service was hard hit by the removal of the residents by the Tulsa Medical College. Out of an FTEE of 23.7, only 5 are physicians. They currently have four physician vacancies. To adequately perform the teaching responsibilities of this medical center, it was opined that they need at least 12 physicians. This service is currently receiving one resident from Tulsa Medical College and two from Oral Roberts University School of Medicine. This has caused the service to reduce their beds from 135 to 86 and to close 2 of the 8 MICU beds.

The physicians interviewed appeared to be both discouraged and frustrated. They indicated that the VA image in the community is of a place where physicians go when they have no other choice.

This medical center's Geriatric Evaluation Unit exists only on paper. This is due mostly to the pressure of caring for the acute patients. It is hoped that as soon as a Chief can be recruited, the unit can get started.

4. SURGICAL SERVICE:

FTEE 12 with vacancies of 2 surgeons. In this confrontation with the medical school, they lost two of their five residents. Surgical Service has 25 beds closed due to funding cuts and the nursing shortage. The staff conducted 2,858 surgical procedures last fiscal year. There is a need for eye surgery at this medical center due to the delays experienced at Oklahoma City. The service has four (three major and one minor) surgical suites plus an endoscopic and a cystoscopic room. They are reported to be adequately furnished and of reasonable size. The support to the operating rooms by Supply Processing and Distribution (SPD) is said to be lacking. The Surgical Service would support nursing being placed in charge of SPD, if supervision was done by the nurse in charge of the operating rooms.

5. MEDICAL ADMINISTRATION SERVICE:

This service has 18 FTEE in Tulsa and 76.2 in Muskogee. They currently have seven vacancies. The acceptance rate is 90 percent. Due to the residency problem, they have tightened up on accepting nonservice connected veterans. However, if the doctor indicates there is a need for care, they do get treated.

Records are reported to be available to treating physicians about 90 percent of the time. This rises to 96 percent after a search is conducted. Most of the problem can be traced to records being held by physicians or in the Tulsa Outpatient Clinic.

The service had 67 undictated medical records as of September 9th, with June 30th being the oldest. Almost half of the deliquent reports belong to the physician assistants. It would appear that the physician assistants write final summaries for patients who expire in the hospital. There were 31 undictated surgical reports with one being over 11 months old (Oct. 1987). There is no way a physician can remember all of the details of surgery after this period of time. Management must stay on top of this situation to assure timely completion of reports.

6. SOCIAL WORK SERVICE:

This service has an FTEE of 12. The Tulsa Outpatient Clinic has four of these. The eight at Muskogee handle the hospital and the southeastern part of the state.

The medical center has 28 contract Community Nursing Homes with none being classified as skilled at this time. The hospital has an approved average daily census of 62 with 9 being placed out on indefinite contracts. The average cost is $46.43 per day.

The service has two alcohol treatment halfway houses. However, without additional funds, they cannot place any veterans in the program. They have $1,300 to complete the fourth quarter. At $25 per day, this will not cover even one veteran for the permitted time frame.

7. DIETETIC SERVICE:

Without a Chief of Service, they have 31 FTEE to provide meals for an average of 120 patients per day. Of the 4.6 dietitians, 1 is stationed in Tulsa.

The kitchen is located in the back of the hospital on the second floor. All trash, including contaminated waste, uses the service elevator which opens directly into the food preparation area. All food supplies, including fresh vegetables and fruits, must also use this same elevator. The floor of the elevator is made of wood, which is cracked and impossible to properly clean. Therefore, fresh vegetables and fruits are being unnecessarily exposed to potentially hazardous germs. This situation must be rectified by new construction or replacement of the elevators.

8. REHABILITATION MEDICINE SERVICE:

This service has an FTEE of 11.3 of which only 6.3 are on board. Their vacancies include a full-time physician and three physical therapists. The clinic is located in the old auditorium of which much of the space is unuseable for rehabilitation including the stage area. There is a need for a audiology clinic at the medical center. It was estimated that there was sufficient work to keep one individual busy running this clinic. The most critical need is for a full-time doctor. The .3 physician can only hit the high spots and many of the decisions concerning treatment fall on the staff.

9. PATIENT REPRESENTATIVE:

At this medical center, the Patient Representative works for the Chief of Medical Administration. Since most of the work load involves handling complaints or concerns that relate to the professional side of the hospital, it is recommended that the Patient Representative be placed directly under the Chief of Staff or Director.

10. NURSING SERVICE:

FTEE 165.7, on board 144.1. This medical center has 117.2 registered nurses and 44.5 nonprofessional nursing personnel. It would appear that with this mix, the professional nursing staff is required to perform tasks that could well be handled by nonprofessionals, thereby keeping the registered nurses for hands-on nursing duties.

The concerns expressed by Nursing Service were mainly salary levels and support from Building Management and Pharmacy. The turnover rate was reported as 30 percent for RNs, 21 percent for LPNs and 37.5 percent for nursing assistants.

11. PHARMACY SERVICE:

There are two Veterans Administration Medical Centers in Oklahoma. Neither one has unit dose established. It was reported that these two hospitals are the only ones in Region Seven without unit dose of any form. It appears that Central Office is waiting for the construction of the new bed tower before implementing unit dose. The reported medication errors do not support the concerns expressed by Nursing Service. However, it has been proven that unit dose is the safest system available to patients when properly utilized.

The pharmacy projects they will fill 377,829 prescriptions in Muskogee and 198,941 in Tulsa this year. Of this number, 66 percent and 55 percent respectfully are mailed. This is expected to be a 22 percent increase over last year. The window waiting time is between 20 minutes and 2 hours according to the time of day.

12. QUALITY ASSURANCE COORDINATOR:

This facility has been very active in the past year in Quality Assurance. All major medical staff committees have been revised to comply with the Joint Commission on Accreditation of Hospitals (JCAH) standards. All services are being provided instructions to assist them in documenting their programs.

To assist the Coordinator in handling the paper flow, it would be helpful if a computer program was developed and provided to the medical centers for their main frame. A practical educational course on Quality Assurance should be developed by the VA and made available through the Regional Medical Education Centers (RMECs) directed at those individuals delivering the care.

13. ENGINEERING SERVICE:

Parking is inadequate at this facility. Management has taken steps to relieve the problem by leasing a parking lot about one block from the medical center. However, even this lot overflows many days. To assist patients, visitors and employees who use this lot in getting to the medical center, the volunteers are raising money to purchase a specially built cart to run between the two points.

The medical center has one dead-end corridor remaining on B wing, 5th floor. The stairwell that serves this wing was not continued to the 5th floor.

14. PROSTHETIC SERVICE:

FTEE 4. This service has a prosthetics representative and two clerks in addition to the Chief. This is one short of the required staffing due to the work load between the Tulsa Outpatient Clinic and the medical center. The Chief must spend one day every other week in Tulsa. This does not leave time for home visits with patients or liaison visits with vendors. Management appears to be handling the prosthetic budget so that no orders are unnecessarily delayed.

15. VOLUNTARY SERVICE:

This service has 19 certified organizations on their Advisory Committee. During the period 10-1-87 through 7-31-88, these organizations provided 33,175 hours of volunteer hours to the patients. The VFW has 18 regularly scheduled volunteers who provided 3,823 hours. The Youth Volunteer Program had 40 enrolled last summer. The medical center did not submit a recommendation for the James H. Parke Memorial Youth Scholarship.

Steps should be taken to provide the Tulsa Outpatient Clinic with an Advisory Committee. The least that should be done is assigning a Deputy Representative from each organization that has an interest in volunteer work at the clinic to a Committee that meets at the clinic.

16. LIBRARY SERVICE:

Central Office should negotiate with the Postal Service for a procedure where the local post offices would set aside undelivered magazines for use by federal hospitals. This would save many dollars for the federal facility.

17. FINDINGS AND RECOMMENDATIONS:

a. The need for eye surgery at this facility has been demonstrated. The VFW supports the medical center's efforts to establish this specialty in surgery (see paragraph 4).

b. The Patient Representative should be placed directly under the Chief of Staff to provide the support necessary to accomplish their duties (see paragraph 9).

c. The medical center is due for a replacement bed tower. After a review of the plans, the organization supports the plan referred to as 3-Consolidated. This plan would cause the least disruption to the medical center and would prove to be the most cost effective over the long run (see paragraph 2).

d. The names of the Ex-POW and Women Veteran Coordinator should be posted in accordance with federal law.

e. A Voluntary Service Advisory Committee should be established for the Tulsa Outpatient Clinic (see paragraph 15).

f. The medical center should take steps to open the Geriatric Evaluation Unit as soon as possible (see paragraph 3).

g. Due to the veteran population in eastern Oklahoma, there is a need for an audiology clinic in Muskogee or Tulsa (see paragraph 8).

h. Steps must be taken to solve the problems associated with handling contaminated waste and food products on the same freight elevator. The prepared foods must pass through the area used to enter the freight elevator which, in itself, is unsanitary (see paragraph 7).

i. The floor in the food preparation area had cracked which allows water to undermine the floor (see paragraph 7).

j. Central Office should make every effort to secure full funding for the alcohol treatment program halfway houses from Congress (see paragraph 6).

k. Both medical centers in Oklahoma do not have unit dose in their pharmacy. Since it has been proven to be the safest way to distribute drugs in a hospital setting, this facility should be funded for the full program as soon as possible (see paragraph 11).

18. EXIT INTERVIEW:

The Director was made aware of all the findings and recommendations contained in this report. He was requested to share with his staff my appreciation for their support during this survey.

ROBERT F. O'TOOLE
Senior Field Representative
National Veterans Service

RFO/gal

STATEMENT OF THE HON. J. ROY ROWLAND

COMMITTEE ON VETERANS' AFFAIRS

FEBRUARY 9, 1989

THIS HEARING WILL COME TO ORDER.

GOOD MORNING. I AM PLEASED TO CHAIR THIS SECOND DAY OF HEARINGS REGARDING THE BUDGET FOR THE VETERANS' ADMINISTRATION -- SOON TO BE THE DEPARTMENT OF VETERANS' AFFAIRS -- FOR FISCAL YEAR 1990.

ON TUESDAY, WE CONCENTRATED ON MANY ASPECTS OF THE VA PROGRAM INCLUDING VETERANS' COMPENSATION AND PENSION BENEFITS, MEMORIAL AFFAIRS, HOUSING AS WELL AS MEDICAL CARE. TODAY, WE DEVOTE OUR TIME TO MEDICAL CARE. ON TUESDAY, WE TALKED ABOUT BUDGET NUMBERS AND THE PHILOSOPHY OF ELIGIBILITY FOR VETERANS BENEFITS AND SERVICES. TODAY, WE WILL EMPHASIZE THE MEANING OF THE BUDGET NUMBERS FOR QUALITY OF VA MEDICAL CARE, FOR THE CONTINUED STRENGTH OF AFFILIATIONS, FOR THE WORK ENVIRONMENT OF MEDICAL STAFF - ESPECIALLY NURSES - AND FOR VETERANS WHO USE THE VA FOR THEIR MEDICAL CARE.

OUR WITNESSES TODAY INCLUDE DEAN SHINE OF THE UCLA SCHOOL OF MEDICINE WHO IS ALSO REPRESENTING A GROUP OF 40 ORGANIZATIONS IN THE FRIENDS OF THE VA AND THE ASSOCIATION OF

AMERICAN MEDICAL COLLEGES. DR. TOM BOWLES, VICE PRESIDENT OF THE GEORGE WASHINGTON SCHOOL OF MEDICINE, WHO IS REPRESENTING THE SPECIAL MEDICAL ADVISORY GROUP OF THE VA. WE ALSO WELCOME LINDA SCHWARTZ OF THE AMERICAN NURSES ASSOCIATION AND CLAUDETTE MORRISSEY OF THE NURSES ORGANIZATION OF THE VA AND REPRESENTATIVES OF SEVERAL VETERANS ORGANIZATIONS.

I WANT TO SAY FOR MYSELF AND, I THINK IT IS SAFE TO SPEAK FOR OTHER MEMBERS OF THE COMMITTEE, THAT WE APPRECIATE THE PRESENCE OF THE WITNESSES. NOT ONLY DO SOME OF THEM COME CONSIDERABLE DISTANCES TO BE HERE, BUT THEY LEAVE JOBS THAT ARE DEMANDING AND IMPORTANT. I BELIEVE IT IS A DIRECT REFLECTION OF THE IMPORTANCE OF THE VA TO AMERICAN HEALTH THAT WE HAVE HAD INTERESTED WITNESSES FOR TWO DAYS OF HEARINGS.

I WILL NOW RECOGNIZE THE RANKING MINORITY MEMBER OF THE COMMITTEE, THE HONORABLE BOB STUMP OF ARIZONA, FOR ANY COMMENTS HE MAY WISH TO MAKE.

HONORABLE CHRIS SMITH, NJ
OPENING COMMENTS ON VETERANS' AFFAIRS FULL COMMITTEE HEARING ON FISCAL YEAR 1990 VA BUDGET REQUEST
FEBRUARY 9, 1989

Thank you Mr. Chairman.

Mr. Chairman, this is the third day our Committee has met to review the FY 1990 VA budget request. As we have examined the proposed funding levels for various VA programs, we have found that the dollars requested do not meet the costs of delivering veterans their due benefits.

I am very pleased to see that Secretary-Designate Edward Derwinski has recently petitioned OMB for a 1989 supplemental and has also increased the 1990 request. I think it remains clear, however, that a funding shortfall still exists and under the current circumstances, I do not see how the VA can provide veterans with the quality services they deserve.

The VA is charged with a tremendous responsibility of containing medical costs at a time when medical costs in general are skyrocketing. But refusing to acknowledge the real need for additional funding is not the right way to contain costs.

I think that we as the legislators of VA programs need to work even harder to try to improve medical care for veterans and at the same time see that the VA receives sufficient funds to administer benefits as Congress intends.

I am, then, very happy to have the opportunity to hear the testimonies of our witnesses today -- to possibly learn of new approaches to these dilemas we face today so that we can help provide for improved services in the future. Thank you again, Mr. Chairman, for your initiative and foresight in this matter.

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEE ON VETERANS AFFAIRS

FEBRUARY 9, 1989

OPENING STATEMENT

MR. CHAIRMAN - HEALTH CARE IN AMERICA IS OF CRITICAL IMPORTANCE TO EVERYONE, ESPECIALLY TO OUR VETERANS WHO ARE FINDING IT INCREASINGLY DIFFICULT to FIND ADEQUATE SERVICE FOR THEIR NEEDS. TODAY MORE AND MORE VETERANS ARE UTILIZI THE VA PROGRAMS, BUT MANY ARE BEING TURNED AWAY FROM MEDICAL CENTERS AND CLINICS DUE TO UNDERSTAFFED FACILITIES OR TERMINATION OF SERVICES.

MR. CHAIRMAN, MEMBERS OF THIS COMMITTEE, WE CANNOT SIT IDLE WHILE THE MEN AND WOMEN WHO BRAVELY SERVED AND SACRIFICED FOR THIS GREAT NATION GO WITHOUT BASIC HEALTH CARE. THE PROPOSED FY '90 VA BUDGET DOES NOTHING TO HELP CORRECT THE INADEQUACIES OF THE HEALTH AND BENEFITS SYSTEM.

THE DEMANDS ON THE VA HEALTH SYSTEM IS STEADILY INCREASING. VA-PAID NURSING HOME CARE IS UP 63%, OUTPATIENT VISITS UP 29%, AND HOSPITAL PATIENTS UP 7%. BUT WHILE THE NEEDS ARE INCREASING, FUNDING IS DWINDLING. THIS MUST STOP.
WHILE MEDICAID SPENDING HAS INCREASED BY 55% AND MEDICARE BY 32% SINCE 1985, SPENDING FOR VA HEALTH CARE HAS INCREASED ONLY 17%.

I FULLY APPRECIATE THE FACT THAT THIS NATION IS IN A FISCAL BIND. BUT WE MUST IDENTIFY ADDITIONAL FUNDS FOR OUR VETERANS PROGRAMS. WE CANNOT GIVE OUR VETERANS THE HEALTH CARE THEY NEED WITHOUT ACCESSIBLE FULLY STAFFED, TOP QUALITY FACILITIES.

IN ORDER TO PROVIDE AN ADEQUATE LEVEL OF SERVICES FOR OUR VETERANS, I FULLY SUPPORT SECRETARY-DESIGNATE DERWINSKI'S REQUEST FOR A SUPPLEMENTAL APPROPRIATION OF $314 MILLION AND 1,539 FULL-TIME EMPLOYEES FOR FISCAL YEAR 1989 AND AN ADDITIONAL $512 MILLION AND 5,093 MEDICAL EMPLOYEES FOR FISCAL YEAR 1990.

WE CANNOT AFFORD TO LET OUR VETERANS DOWN. NOT NOW, NOT EVER.

THANK YOU.

STATEMENT OF THE HONORABLE MICHAEL BILIRAKIS
FEBRUARY 9, 1989

MR. CHAIRMAN, THANK YOU FOR CALLING THIS HEARING IN ORDER TO DISCUSS THE PROPOSED BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 1990.

IN ALL HONESTY, I MUST VOICE MY CONCERNS OVER THE DRASTIC SHORTCOMINGS IN PROPOSED BUDGET AND SPECIFICALLY IN THE PROPOSED MEDICAL CONSTRUCTION BUDGET. EVERY YEAR, THE VETERANS ADMINISTRATION PROPOSES, AND THE OFFICE OF MANAGEMENT AND BUDGET SLASHES. FOR THIS FISCAL YEAR, THE V.A. REQUESTED FUNDING FOR THE 120 BED NURSING HOME IN LAKE CITY, FLORIDA, AND OMB REJECTED FUNDING FOR THIS MUCH-NEEDED FACILITY. FUNDING FOR THE PROPOSED 290-BED LONG-TERM PSYCHIATRIC FACILITY IN GAINESVILLE, FLORIDA FOR WHICH I APPLAUD THE VETERANS ADMINISTRATION'S REQUEST, WAS ALSO REJECTED BY OMB. IN ADDITION, I MUST ASK, WHAT HAS HAPPENED TO THE SLATED HOSPITAL FOR EAST CENTRAL, FLORIDA? I MUST SAY THAT MARCH 15, 1989, THE EFFECTIVE DATE FOR THE ESTABLISHMENT OF THE DEPARTMENT OF VETERANS AFFAIRS, WILL NOT COME SOON ENOUGH IN THIS MEMBER'S OPINION. ONCE A CABINET LEVEL DEPARTMENT, SECRETARY-DESIGNATE, EDWARD DERWINSKI, WILL ADVOCATE FOR AMERICA'S VETERANS AND CHALLENGE OMB'S ARBITRARY BUDGET CUTS.

THE VETERANS ADMINISTRATION REQUESTED APPROXIMATELY $950 MILLION FOR THE UPCOMING FISCAL YEAR FOR THE MEDICAL CONSTRUCTION BUDGET BUT OMB SLASHED THAT REQUEST IN HALF. THIS IS OF DEEP CONCERN TO ME IN LIGHT OF THE RECENT VA CAPITAL FACILITIES STUDY (CFS). THAT STUDY ESTIMATES THAT $1.45 BILLION IN CONSTRUCTION COSTS

WOULD BE REQUIRED TO CORRECT THE DEFICIENCIES IN THE FACILITIES NATIONWIDE. I DO NOT NEED TO EMPHASIZE THE OBVIOUS FACT THAT THE DETERIORATION OF VA FACILITIES HAS A PROFOUND AFFECT ON THE QUALITY OF HEALTH CARE DELIVERY TO VETERANS. THE DECREASE IN FUNDING FOR THE MEDICAL CONSTRUCTION BUDGET AND SPECIFICALLY THE $41.5 MILLION DECREASE IN FUNDING FOR NURSING HOMES ARE TROUBLESOME IN VIEW OF THE CAPITAL FACILITIES STUDY.

THE NEED FOR NEW CONSTRUCTION AND REPLACEMENT FACILITIES IS MOST APPARENT IN THE STATE OF FLORIDA WHERE 1.5 MILLION VETERANS RESIDE. 15,000 VETERANS MOVE PERMANENTLY TO FLORIDA EVERY YEAR. THIS IS A GREATER GROWTH RATE IN VETERAN POPULATION THAN ANY OTHER STATE IN THE COUNTRY. THE GROWING NUMBER OF AGING VETERANS IN FLORIDA ALSO POSES A PARTICULAR HEALTH CARE PROBLEM FOR THE VETERANS ADMINISTRATION AND ONE WHICH MUST BE RESOLVED IMMEDIATELY. NINE PROJECTS IN FLORIDA WHICH WERE SLATED BY THE VA FOR INITIATION IN FY90 AT A COST OF $282 MILLION WERE POSTPONED.

IT IS WELL KNOWN BY MEMBERS OF THIS COMMITTEE THAT I FEEL THE VA BUDGET HAS BEEN A VICTIM OF SHORTSIGHTED BUDGET CUTS. I CERTAINLY DO NOT BELIEVE IT IS ACCEPTABLE TO BALANCE THE FEDERAL BUDGET ON THE BACKS OF VETERANS, NOR DO THE MAJORITY OF MY COLLEAGUES. WE MUST BE CAUTIOUS IN THE ALLOCATION OF VA RESOURCES AND PROVIDE VA SERVICES AND BENEFITS WITHIN THE BEST OF OUR ABILITY.

WITH REGARD TO THE OVERALL VA BUDGET FOR FY90, THE ADMINISTRATION'S BUDGET REQUESTS $28.6 BILLION IN APPROPRIATIONS FOR EXISTING PROGRAMS. THIS WILL NOT PROVIDE ADEQUATE FUNDING FOR CURRENT SERVICES. AS WE ALL KNOW, CURRENT FUNDING IS INSUFFICIENT THE SYSTEM IS PLAGUED WITH STAFF SHORTAGES, TERMINATED SERVICES AND OTHER PROBLEMS WHICH HAVE LED TO THE TURNING AWAY OF VETERANS. IT IS PREDICTED THAT THE VA WILL SUFFER A $1 BILLION SHORTFALL IN FISCAL YEAR 1990.

I ALSO HAVE CONCERNS REGARDING THE PROPOSAL TO CHARGE 0% TO 20% SERVICE-CONNECTED DISABLED VETERANS FOR NONSERVICE-CONNECTED HEALTH CARE, AND (1) TO HAVE NONSERVICE-CONNECTED VETERANS IN HIGHER INCOMES AND (2) THOSE CATEGORY C PENSION VETERANS IN HIGHER INCOMES PAY COPAYMENTS.

IN CLOSING, I WISH TO TOUCH UPON A POSITIVE BUDGET PROPOSAL -- THAT BEING THE $112 MILLION FACILITY AT PALM BEACH, FLORIDA. THIS FACILITY IS LONG OVERDUE AND I AM PLEASED THE VA REQUESTED ITS FUNDING.

THANK YOU MR. CHAIRMAN.

Testimony
Submitted to
THE HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS AFFAIRS
Thursday, February 9, 1989

By

THE HONORABLE WES WATKINS
Member of Congress
Oklahoma's
THIRD DISTRICT

On Behalf of an
VETERANS' OUTPATIENT CLINIC
In Durant, Bryan County,
Oklahoma

Mr. Chairman, Members of the Committee. Mr. Chairman, the Honorable John Paul Hammerschmidt, who is my neighbor to the east, keeps most of Western Arkansas from being in the Third District of Oklahoma.

Mr. Hammerschmidt and his very capable staff have on numerous occasions assisted me to help Oklahoma veterans in need. I am proud to take this opportunity to publicly thank him.

And, I appreciate the opportunity to appear before you today on behalf of the veterans of southern, eastern, and central Oklahoma, mostly within the Third Congressional District of Oklahoma, which I have the honor to represent.

We are all aware of the budget constraints and the situation in which we have been left by the preceding Administration. At a time when the Nation's veteran population of 27,350,000 is aging and naturally requires more medical attention, it appears that not all are taking the admonition of Mr. Lincoln that we must "care for him who shall have borne the battle and for his widow and orphan..."

I will not repeat what you've already heard and know. The position of the veterans and their relationship with our government, which they fought to preserve, has been adequately expressed by those much more eloquent than I.

Mr. Chairman, Members of the Committee, I don't envy you your task, which you do exceedingly well. I'll continue trying to convince my Appropriations colleagues that the veterans, their dependents and survivors should not bear a disproportionate share of the necessary budget shaving.

Last year, the outstanding Veterans Regional Medical Center in Muskogee, which serves a part of the 20-county Third District, suffered a real blow. A participating medical teaching facility, due mostly to declining enrollments and personnel commitments closer to the Tulsa site, withdrew 27 medical residents from the Muskogee VARMC.

We have yet to recover.

Through heroic efforts, eight of those needed physicians have been replaced - and we have been assured by Veterans Administration Central office that recruitment will continue until the staff is again complete. Even so, the permanent staff at Muskogee is vastly overworked, and I commend them for their diligence. In the meantime, appointments are being rescheduled and patients are being referred and transferred. This, in turn, places an extraordinarily extra workload on Oklahoma City, Dallas, and Fort Smith.

Durant, Oklahoma, in my District, is about 150 miles from everywhere. It is 150 miles from Oklahoma City. It is 150 miles from Muskogee. It is 150 miles from Dallas. It is almost 150 miles from Lawton, where an outpatient clinic has been established with high expectations for great results, I am told by my friend and colleague, the Honorable Dave McCurdy.

Durant is home to a former 125-bed health care facility which is no longer being used for that purpose. A part of the former Bryan County Memorial Hospital is currently being used by the Choctaw Nation of Oklahoma for office space. The rest of it is unused.

I have not personally examined the facility recently, which has been replaced by a new, updated hospital. But at one time it was one of the finest small hospitals in south central Oklahoma and north central Texas.

Durant is the core center and one of the key trade centers of that area. It lies on US 70, the east-west highway across the bottom of Oklahoma, and is also served from the northeast-southwest by US 69, which is one of the few diagonally built highways in Oklahoma: Most of our roads run east and west or north and south dating to the original survey. It's difficult, sometimes, to get from here to there because of that.

A number of retired military and former veterans live in the area. As a matter of fact, in the mostly rural 20-county area is home to 58,250 veterans as of March 1, 1988, over 15 percent of the state's 401,000 veterans. The 1980 census data reports that only one of the counties had less than 30 percent of the male population 16 years of age and older who were not veterans. One of the most populated counties boasts a veteran population just shy of 40 percent. Oklahoma, as most of you may recall, was the home of the 45th - the Thunderbird Divsion - of World War Two and Korean War fame.

The per capita income for the state is $6,858, and Ladies and Gentlemen of the Committee, I assure you that the Third District hasn't added much to the plus side of that number, for per capita income in only a few of the 20 counties exceeds the state average. One has an average per capita income of slightly above $5,000, which is less than Hong Kong, I am told. And most of the rest, particularly the area on which we are specifically concentrating, the per capita income is less than $6,000. As you may recall from my repeated efforts to create new jobs through economic development in the Third District, we are not overwhelmed with prosperity, but we are making progress.

Some of the veteran population is more easily served by the VA facilities at Muskogee, Oklahoma City, and Fort Smith, it is true. However, those in the deep regions, far from any facility, could much more easily be served and, I think, more economically, by an outpatient clinic located in the former Bryan County Memorial Hospital. This in turn could ease some of the workload at the other facilities.

There is some equipment there, I am told. There is adequate space. It would, of course, require personnel and some modernization and I know that dollars are short. I realize that we can not have a veterans facility in each county. But the Bryan County Veterans Outpatient Clinic could and would serve a large southern Oklahoma and north Texas veteran population, benefitting both the veteran and the Veterans Administration, in my judgment.

I ask this committee at the minimum to authorize a study to determine if the area veteran population could not more easily and economically receive the health care benefits they have earned at an outpatient clinic in Durant.

And, I am told by my veteran friends, a reversal of the current 60-day prescription refill policy back to the previous policy of each six months would also reduce some of the demand on the existing, over-extended centers and also lessen veteran's travel frequency.

As I mentioned, sometimes have difficulty getting from here to there.

Thank you for allowing me to appear before you today on behalf of Oklahoma's proud but deserving veteran population.

I will be happy to try to respond to any questions, Mr. Chairman.

-30-

Friends of VA
Medical Care and Health Research

Budget Proposal for FY–1990

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VA Medical Care

GOALS OF THE DMS

The Veterans Administration (VA) was established in 1930 to administer federal programs which provide benefits to the nation's veterans. One of the most important responsibilities, providing health and medical care services, is carried out through a nationwide network of health centers. The Department of Medicine and Surgery (DMS) operates the VA's nationwide health care system. In FY-88, the system consisted of 172 medical centers (at least one of which is in each of the mainland states, the District of Columbia, and Puerto Rico), 233 outpatient clinics, and nearly 150 nursing home units and long-term care domiciliaries. In FY-88, the VA provided over 20 million outpatient visits and treated over 1 million hospital inpatient episodes, making it the largest health care system in the nation.

The DMS considers the provision of quality care to eligible persons its highest priority. To meet that goal, the system encompasses a full range of health services for individuals from early adulthood through their older years. Acute care and extended care are part of those services. VA physicians diagnose and treat patients for a wide variety of clinical problems, including cancer, AIDS, alcoholism, and post-traumatic stress disorder. In addition, the VA offers opportunities for involvement in medical education and research programs that provide a stimulating environment for practitioners and contribute to the high caliber of the overall medical program. Through affiliation arrangements with 103 medical schools, 59 dental schools, and over 850 other health professional schools, the VA makes an important contribution to the training of future health care providers, many of whom will spend their careers in the VA system. The DMS appropriation supports this array of sophisticated programs.

CHALLENGES TO THE SYSTEM

As does the entire health community, the VA faces some serious health challenges. Two issues that demonstrate the severe financial stress faced by the VA system are the national nurse shortage and the AIDS epidemic. Congress has attempted to support the VA's efforts in meeting these challenges by enacting authorizing legislation. For instance, P.L. 100-322, enacted in May, 1988, provides the authority for bonus pay to recruit and retain quality nursing staff. Similarly, P.L. 96-330, enacted in August, 1980, provides special salary rates for VA physicians. These special pay scales are necessary to enable the VA to offer competitive compensation to health care professionals. Unfortunately, the legislation addresses, but does not solve the VA's staffing problems. It establishes the necessary salary flexibility, but does not meet the opportunity with the necessary funds. As a result, the VA has been forced to compromise the resources in accounts for VA infrastructure needs (e.g. equipment, construction and repairs) to meet salary commitments. An increased appropriation is needed to support the programs established in recent legislation and protect the VA's infrastructure accounts from deterioration.

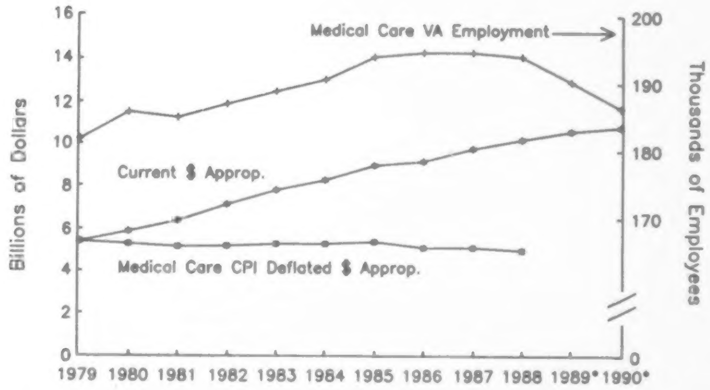
In response to the challenge of AIDS, the VA has treated over 5,000 persons, or seven percent of all the nation's AIDS cases. In 1988 alone, the VA treated nine percent of the nation's AIDS cases, at a cost of $122.6 million. Each year AIDS care at the VA costs between $6,895 and $34,000 per patient, depending on the stage of the infection. VA facilities providing AIDS care

are not fully reimbursed for the costs. In addition, the Occupational Safety and Health Administration developed universal AIDS precautions that will cost the VA $28 million to implement in calendar-year 1989. Like the special salary rates, the costs to the VA associated with AIDS have resulted in funding shortfalls.

RECENT FUNDING CONSTRAINTS

The chart below illustrates an example of how thin the VA medical care system has been stretched. Due to unhealthy budget conditions, the DMS has not been able to afford to meet congressionally-mandated employment levels. The DMS currently employs 191,800 full-time employee equivalents (FTEE); this is nearly 3,000 fewer than the congressionally-mandated FTEE level. Under current budget constraints, DMS simply cannot afford to hire additional staff.

VA Appropriations vs. Employment
1979–90



Source: Veterans Administration

*VA Estimates

Over the past decade, the medical care appropriation has not included a real dollar increase. At the same time, the VA has increased the amount of care provided. VA data indicates that the system has offered more care without real growth in funding for ten years. Since 1980, the VA workload has increased by 60,000 inpatient treatments, 5 million outpatient visits, and 38,000 nursing home stays -- without an increase in real dollar spending.

The funding for FY-89 falls at least $600 million short of the amount needed to supply care to eligible veterans. This shortfall has stretched the VA beyond reasonable limits and forced reorganization of services. For example, the waiting period for prosthetic devices has increased substantially. In September, 1988, the Chief Medical Director was compelled to authorize restrictions on the number of veterans treated and a cut back in services, such as limitations on the availability of transplant services. The results of working with too limited resources have brought into play ethical and moral considerations, such as timeliness and access to care. If forced to continue operating with insufficient funding, the VA will be in danger of impairing services, eroding the standards of medical care, and threatening the symbiotic relationship between academic health centers and DMS facilities. A study by staff members of the House Veterans' Affairs Committee concludes, "The fiscal health of the VA medical system is not good. This is an unsettling conclusion, reached after two investigations into the current operations of the VA medical care system."

The federal government must begin now to restore VA medical care funding to appropriate levels and to minimize the damage already experienced to the system. Further erosion will jeopardize the VA's ability to meet current responsibilities and future health care challenges. According to Wendell Musser, M.D., President of the National Association of the VA Chiefs of Staff, "The national deficit, and of necessity the changes in attitude toward programs such as the VA, are forcing us to tighten our budget belt beyond all reasonable expectations. The entitlement and statutory necessities follow from law to law and regulation to regulation, yet the budgets and expendable resources stay static." To remedy the damage that has already taken place, and to reverse a dangerous trend, the VA medical care budget must be given careful attention and increased funding. The Friends of VA Medical Care and Research take seriously this warning. In FY-90, the VA medical care appropriation must begin to rectify past shortfalls and also accommodate the costs of the new entitlements.

RECOMMENDATION FOR FY 1990

The Friends of the VA Medical Care and Health Research support a medical care appropriation of $12.42 billion for the coming fiscal year. This recommendation is consistent with that of the Independent Budget, developed by four veterans service organizations, reflecting strong agreement among consumers of the VA health care system as to current and future requirements. This funding level will allow the VA to meet the needs of those eligible for care as well as restore fiscal health to the system.

VA MEDICAL CARE BUDGET
(in billions of dollars)

FY-89 APPROPRIATION	$10.54
FY-90 CURRENT SERVICES	$12.02
FY-90 RECOMMENDATION	$12.42

The current services funding level of $12.02 billion will restore stability and adequacy to the VA medical care system. In other words, an additional $1.5 billion is necessary for the FY-90 appropriation to maintain the current level of effort. Personnel costs comprise approximately 60 percent of the DMS budget. Over $600 million of the $1.5 billion will be consumed by employment costs. Part of the $600 million is associated with P.L. 100-322; another portion will contribute to the 4.1 percent federal employee salary increase which took effect on January 1, 1989.

PREPARING FOR THE FUTURE

Additional funding beyond $12.02 billion is necessary to correct recent actions by the VA to accommodate inadequate funding and to implement enhancements to the VA medical care system. Many of these improvements are designed to prepare the VA medical care system for the challenges of the progressively aging veteran population. The number of veterans over age 65 will increase by over 60 percent before the turn of the century. Recent studies have shown a correlation between aging, health, and income. The percentage of veterans with low incomes increases after age 55. Older veterans require more care and more costly care than other populations. The Friends of the VA Medical Care and Research request an additional $400 million to begin geriatric programs and to meet other specific areas of critical need. They include:

1. Extended Care Program This comprehensive program encompasses 11 specific improvements, including establishing a VA hospital-based home care (HBHC) program at each VA medical center; increasing adult day health care (ADHC) programs; increasing the nursing home census; and establishing geriatric evaluation units (GEUs). The total cost of the extended care program is $94 million.

2. Outpatient Workload Increase VA data indicates recent rapid growth in outpatient care in the last year. To support this shift toward less costly provision of care, the VA should plan to hold constant the hospital inpatients workload and expand outpatient care visits to 23.7 million in FY-90. This proposal will cost $100 million.

3. Health Manpower Training A grant of $5 million would provide awards to institutions with VA medical center affliations to increase training for allied health professionals in 15 disciplines with shortages.

4. Associate Degree Program To enhance the pool of qualified health professionals, $8.4 million is requested to support select low-salaried VA employees in pursuing nursing and allied health education degrees. Two years of service in the VA would be required in return for each year of academic support.

5. Postgraduate In-service Training Professional in-service training and continuing medical education are crucial to maintain high quality health care as well as to recruit and retain high quality personnel. In light of new technologies and to meet the needs of the aging veteran

population, it is particularly critical at this time to provide the $6 million necessary for this program.

6. AIDS-Related Training Programs To support the high cost of AIDS-related care and conduct AIDS education activities and research, $3 million is requested.

7. Geriatric Training Enhancements In FY-90, $1.4 million is requested to meet the costs of increasing the number of geriatric medical and dental residencies who will provide care for aging veterans.

To meet today's health challenges and to prepare for future medical needs of those who have served our nation, the VA must receive increased funding. A medical care appropriation of $12.42 billion for FY 1990 is necessary. This level of funding will insure that veterans receive high quality medical care in a timely manner. Equally important, the Friends of the VA Medical Care and Health Research budget request will enable the VA to prepare to accomodate the needs of the aging veteran population.

VA Health Research

> The Veterans Administration deserves much more recognition for the role it has played in the battle to conquer disease and disability. All of us benefit from a strong VA research program and we must do all that we can to see that it thrives and grows.
>
> -- Mary Lasker

BENEFITS OF THE VA RESEARCH PROGRAM

Veterans and their families perhaps can best describe the important role of the VA in the area of health research. Six partiicpants from across the country share their experiences in VA programs.

"I had a heart attack in 1984 and was a patient at the San Francisco VA Medical Center. I owe my entire well-being to everything they did for me. I got the finest medical care from top quality doctors who were at the San Francisco VA because of the research opportunities there. A few years later, when my heart disease worsened, I was asked by the researchers to participate in the study of a new drug and since taking the drug, I am back in conditions of good health. I've resumed my regular activities. I couldn't be more appreciative of what the San Francisco VA research program has done for me."

- James Castle
San Francisco, California
(Mr. Castle served in the Army in
the Pacific from 1943 - 1945.)

"I have been treated for AIDS at the Ann Arbor, Michigan VA Medical Center. Because I am a veteran, I have had a chance to be in the AIDS drug testing program at the Medical Center. I have a terminal disease, but the doctors at the VA have done an excellent job of helping me as much as they can. They encourage me to keep my spirits up. The nurses are wonderful. Unfortunately, there aren't enough of them and so they are really overworked--but, they still smile.

- Tyrone Clayton
Ypsilanti, Michigan
(Mr. Clayton served in the Army at
Stuttgart, West Germany from 1973 -1976.)

"In 1983, my husband, Silvio, was diagnosed with Alzheimer's disease. Of course, there is no cure, but the doctors at the Mt. Sinai School of Medicine suggested that as a veteran, he might apply to participate in a research program at the Bronx VA Medical Center where new drugs are being tested. The program can only admit a limited number of patients but because Silvio was otherwise healthy, he was accepted. This special VA program has made a real difference for us. He gets wonderful medical care at the VA and the experimental drug he is taking seems to be delaying his mental deterioration. I can't speak highly enough about the physicians and nurses at the VA who have been trying to help my husband. They are special, caring people."

- Nancy Falco
Hawthorne, New York
(Mr. Falco served in Europe in World
War II and was decorated with the Silver
Star.)

"I had been really sick with chronic hepatitis. Because I had been in the Service, I was able to enroll in a special program at the St. Louis VA Medical center where doctors were doing research on the disease. Since taking the medications that they are studying, I am almost a new man! I feel better and I have my energy back. The research program at the St. Louis VA has helped me tremendously."

- Klagert Dickerson
St. Louis, Missouri
(Mr. Dickerson served in the Army in
Korea from 1959-1961.)

"When I went for my annual check up in 1986, my doctor discovered that I had lung cancer. He told me that there was no treatment for the disease and that I probably had only a few months to live. I had never gone to the VA for medical care but decided to go to the San Antonio VA hospital to see if the doctors there could help me. I was enrolled in a special research program that was testing new cancer drugs. The doctors explained that the drugs might not help me but that through the research they might learn how to help other lung cancer patients. Still, the drugs do seem to help. Two years after being told that I had two months to live, I am doing pretty well. I believe that I wouldn't be here today without the doctors and nurses at the San Antonio VA cancer research program."

- Elzy Bishop
San Antonio, Texas
(Mr. Bishop served in the Army in the
Pacific from 1942 until he was wounded
in 1945.)

"After being diagnosed as having hypertension, I was able to enroll in a special research program at the San Diego VA Medical Center. This was a great opportunity for me to try the newest drugs being developed to help my condition. In addition, I felt that my participation in the research might contribute to helping others with hypertension. I did much better on the experimental drug than I had done on the medicine I had been prescribed by my private physician. I found the doctors and nurses at the San Diego VA Medical Center to be dedicated professionals and I have nothing but praise for them.

Unfortunately, I can not longer participate in any VA research program because of new policies that restrict veterans above a certain income level from treatment and/or admission to VA hospitals. I wish that an exception to this rule could be made for research patients. People like me who really want to help the research teams and physicians should have that opportunity to contribute."

- Michael Digan
Carlsbad, California
(Mr. Digan served in the a Navy in the Pacific
from 1943 until 1946.)

A RECORD OF SUCCESS -- HOW THE RESEARCH PROGRAM HAS IMPROVED THE QUALITY OF VA MEDICAL CARE

The quality of care provided to veterans in VA medical centers around the country is significantly enhanced by the presence of medical, rehabilitation, and health services research programs. These programs serve to attract to the VA distinguished physician scientists who not only engage in research activities but also provide medical care to veterans. In addition, research performed in the VA by M.D. and Ph.D. scientists has led to improvements in the diagnosis, treatment and prevention of a number of diseases and disorders:

- A VA researcher in New Orleans received a Nobel Prize in Medicine for his discovery of an effective treatment for prostate cancer.

- A cooperative VA study involving VA medical centers across the country played an integral role in the recently publicized discovery that low doses of aspirin can reduce the incidence of heart attack among men.

- A similar cooperative VA study was the first to provide evidence that drug treatment for hypertension can prevent death and disability from stroke and heart attack. A VA researcher in Washington, D.C. received the Lasker Foundation's Basic Medical Research Award for his work on this study.

- Another VA-sponsored scientist at the Los Angeles VA Medical Center received the Lasker Award for discoveries leading to the development of CT scanning -- the most useful technology available for the diagnosis and management of brain disorders.

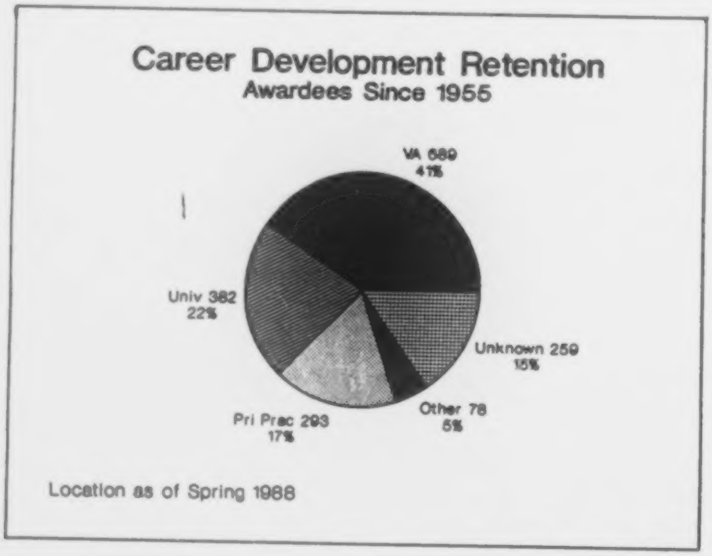
- A Nobel Prize was presented to a scientist at the Bronx VA Medical Center for discoveries regarding radioisotopes, which are used in the diagnosis and treatment of a host of diseases.

- The VA Health Services Research program supported a study at the Sepulveda, California VA Medical Center which determined that Geriatric Evaluation Units (GEUs) for the care of the frail elderly are often an effective alternative to nursing home admission. The benefits of GEUs identified in the study include improved functional status, extended survival, and less use of acute care and long-term institutional services.

- The VA rehabilitation research program has been responsible for most of the major developments in artificial limb design and function over the past 30 years. In 1979, researchers at the Tucson VA Medical Center reported the development of a new approach to rehabilitating amputation patients. This technique, now used in a number of VA Centers around the country, has significantly reduced the average length of hospital stay for these patients and resulted in multi-million-dollar cost savings for the VA.

These are just a few examples of important discoveries made by VA researchers that have resulted in improved health care for veterans and, moreover, have benefited the population at large.

Another measure of the success of the VA research program is the effectiveness of its training efforts. The VA Career Development program provides grants to support the training of future investigators -- a critically important effort given documented personnel shortages in some areas of health research. Of course, the principal goal of the program is to train researchers who will remain in the VA system. As shown below, the program has been extremely effective. A total of 63% of career development awardees trained since 1955 have remained in an academic setting -- the majority in the VA system. This has been a fairly constant trend over the last thirty years, despite the fact that VA salaries are substantially below the average income for private practice.



CURRENT EFFORTS TO IMPROVE THE HEALTH OF VETERANS

In terms of current VA research efforts, the program continues to focus primarily on the diseases and disabilities that most commonly afflict the veteran population. Examples of such research include studies of:

- diseases of the immune system including rheumatoid arthritis, multiple sclerosis, diabetes, and systemic lupus erythematosus
- the medical problems of the elderly including osteoporosis, increased susceptibility to viral infections, and hearing loss
- Alzheimer's disease and other forms of dementia
- the psychophysiology of post-traumatic stress disorder
- various forms of cancer
- blindness and disorders that impair vision
- drug and alcohol dependence
- crippling spinal cord and head injuries and neurological disorders such as Parkinsonism and epilepsy
- heart attack, stroke, hypertension, and circulatory disorders
- lung diseases including emphysema
- kidney disease and acute renal failure requiring dialysis
- digestive diseases and liver disease
- blood disorders and bone marrow disease

Adequately funded, these research activities have enormous potential not only to improve the health of veterans and the population at large but also to reduce health care costs.

RECENT FUNDING CONSTRAINTS - LOST OPPORTUNITIES

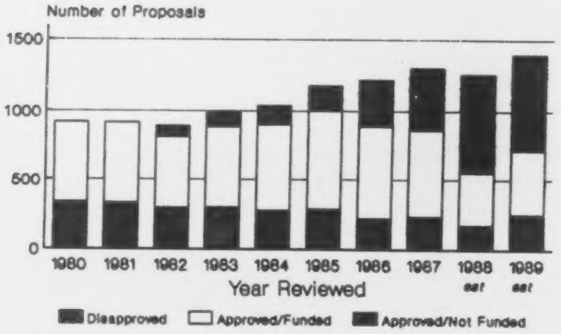
Funding levels for VA research have fluctuated dramatically in recent years. This is a distressing trend, as funding constraints have resulted in lost opportunities. Health-related research leads to improved care and tools that improve and prolong life. Shortfalls in funding for VA research deny VA medical centers of the vitality that they once enjoyed.

Last year, the Friends of the VA urged the Congress to provide a $235.6 million VA research budget in order to restore the program to its FY 1985 level of effort, thereby recapturing losses sustained during the previous three fiscal years. The Congress responded by providing a $210.2 million budget -- a 9% increase over FY 1988 and a much-appreciated first step toward revitalizing the VA research effort. However, the medical research program has yet to recover fully from reductions sustained between 1985 and 1988. The dramatic impact can be seen clearly by examining the activities of the merit review program, which funds the vast majority of VA medical research grants:

- The number of merit review awards, which dropped from 722 in FY 1985 to approximately 385 for FY 1988, is projected to rise to just under 500 for the current year -- still significantly less that the total of four years ago.

- The percentage of programs approved by panels of scientific experts that are actually funded dropped dramatically between FY 1985 and FY 1988. While that percentage is projected to increase modestly to 41% for the current fiscal year, it remains far below the level of four years ago.

This change in the VA's ability to fund meritorious medical research grants is shown graphically below. As depicted, VA funding has been unable to keep pace with medical research opportunities. In 1981, the VA supported 100% of the grants approved by merit review boards. For FY 1989, more than half (59%) of the research proposals judged to merit VA support will go unfunded.


Merit Review Proposals

1980-1989

Recruitment and retention of first-rate talent into the VA is dependent upon the potential of stable opportunities for continued professional growth. Budgetary constraints on the VA's ability to support meritorious research proposals will discourage medical researchers, including physicians, from careers in the VA. Staff quality and morale will be hindered by the decline of the research programs. In addition, it is important to recognize that unfunded grants translate into lost opportunities -- potentially, the loss of discoveries that could lead to dramatic improvements in medical care.

RECOMMENDATION FOR FY 1990

The Friends of VA Medical Care and Health Research recommend a total FY 1990 VA research budget of $249.1 million. This represents an increase of 19% over the FY 1989 appropriation.

HEALTH RESEARCH
(in millions)

	FY 1989*	FY 1990 Recommendation
Medical Research	$179.1	$215.3
Rehabilitation Research	$ 19.0	$ 22.4
Health Services Research	$ 9.4	$ 11.4
CDC-Agent Orange Study	$ 2.7	**
TOTAL:	$210.2	$249.1

* does not include transfers

** to be supported with funds carried over from FY 1989

It is important to recognize that funding at this level will simply continue moderate growth in the activities of the rehabilitation and health services research programs and restore the FY 1985 level of effort for the medical research program as follows:

- Support would be provided for 1,840 projects -- the same number funded in FY 1985. Unfortunately, a significant percentage of meritorious research grant applications would continue to go unfunded under this recommended budget.

- Twenty-six cooperative studies would be funded -- the same number supported in FY 1985.

Under this recommended budget, only three activities would be expanded:

- Two hundred fifty individual career development awards would be supported, compared to 200 funded in FY 1985. An additional 50 FTEs are required to accommodate a one-year extension in the length of the training period.

- A $4 million increase above current services is recommended for the Special Initiatives program, which targets support to areas of special interest such as spinal cord regeneration, geriatrics, alcoholism, and schizophrenia. Of particular importance, this increase will continue funding for 6 new research centers and a total of approximately 100 new and ongoing projects on AIDS. It will allow for 10 additional projects on post traumatic stress disorder.

- A $3 million increase above current services is recommended for grants to support the purchase of large-scale equipment.

The Friends of VA Medical Care and Health Research believe that the FY 1990 VA research budget of $249.1 million is necessary to continue moderate growth in rehabilitation and health services research and to restore reductions in the medical research program. In addition, targeted increases are recommended for three specific programs of special importance to the VA. Funding at this level will strengthen the VA research program and enhance its ability to contribute significantly to the improvement of health care for veterans and the population as whole.

CONCLUSION

Although the VA's efforts are designed to support the needs of veterans, those efforts do not benefit veterans exclusively. The nation has benefited on a global scale as a result of the impressive medical advances achieved at the VA. In the interest of improving the health of all Americans, it is necessary to increase funding for VA medical care and health research.

The health programs administered by the VA represent our nation's commitment to those who have served this country in times of greatest need. Providing high quality care must continue to be of the highest national priority. In 1988, Congress and the President acknowledged the importance of veterans' concerns by elevating the VA to a cabinet-level department. In 1989, this commitment should be continued and enhanced by providing an appropriation that will prepare the DMS to meet current and future health care challenges.

The diverse group of organizations listed on the proceeding page have united as Friends of VA Medical Care and Health Research to promote support for these important programs. While we recognize the need for fiscal conservatism, we do not believe that it is prudent or responsible to sacrifice the success of the VA's programs in attempting to reduce the federal budget deficit. The Friends of the VA Medical Care and Health Research respectfully urge adoption of the outlined budget proposal.

Friends of VA Medical Care and Health Research

ORGANIZATIONS IN SUPPORT OF FY-1990 PROPOSAL
February 7, 1989

Alliance for Aging Research
American Academy of Dermatology
American Academy of Neurology
American Academy of Opthamology
American Academy of Orthopedic Surgeons
American Academy of Otolaryngology
American Association of Chairmen of Departments of Psychiatry
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Dental Schools
American Association of Directors of Psychiatric Residency Training
American Cancer Society
American College of Clinical Pharmacy
American College of Nuclear Physicians
American College of Psychiatrists
American College of Rheumatology
American Diabetes Association
American Federation for Clinical Research
American Gastroenterological Association
American Heart Association
American Lung Association
American Optometric Association
American Psychiatric Association
American Society for Clinical Oncology
American Society of Hematology
Arthritis Foundation
Association of Academic Health Centers
Association of American Medical Colleges
Association of Biotechnology Companies
Association of Medical Schools' Departments of Biochemistry
Association of Pathology Chairmen
Association of Professors of Medicine
Association of University Professors of Neurology
Association of University Professors of Opthamology
Association of VA Investigators and Research Administrators
Digestive Disease National Coalition
Epilepsy Foundation of America
Huntington's Disease Society of America
Lupus Foundation of America
Juvenile Diabetes Foundation International
National Association of Private Psychiatric Hospitals
National Council on Alcoholism
National Organization for Rare Disorders
National Osteoporosis Foundation
National Sudden Infant Death Syndrome Foundation
Radiological Society of North America
Society for Neuroscience
Society of Nuclear Medicine
Society for Surgery of the Alimentary Tract

STATEMENT OF

KENNETH I. SHINE, M.D.

DEAN

UNIVERSITY OF CALIFORNIA, LOS ANGELES

SCHOOL OF MEDICINE

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

ON BEHALF OF THE

FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH

FEBRUARY 9, 1989

Good morning. I am Dr. Kenneth Shine, Dean of the UCLA School of Medicine in Los Angeles, CA. I am here today on behalf of my university, as well as the Association of American Medical Colleges, and the Friends of the Veterans Administration Medical Care and Health Research. The Friends of the VA are a diverse group of organizations that share a common concern for the VA's medical care and health research programs. We urge that these important programs receive the support necessary to enable them to continue providing high quality medical care and services to the men and women who have risked their lives in defense of our country. I request that the list of organizations supporting the Friends of the VA recommendation and the Friends of the VA Budget Proposal for FY-90 be included in its entirety for the official hearing record.

One of the VA's most important responsibilities, providing health and medical care services, is carried out through a nationwide network of health centers, managed by the Department of Medicine and Surgery (DMS). In FY-88, the VA provided over 20 million outpatient visits and over 1 million hospital inpatient episodes, making it the largest health care system in the nation, perhaps the world.

The DMS considers the provision of quality care to eligible persons its highest priority. VA physicians diagnose and treat patients for a wide variety of clinical problems, including cancer, AIDS, alcoholism, and post-traumatic stress disorder. The DMS appropriation supports an array of sophisticated programs. In addition, the VA offers opportunities for involvement in medical education and research programs that provide a stimulating environment for practitioners and contribute to the high caliber of the overall medical program. Through affiliation arrangements with 103 medical schools, 59 dental schools, and over 850 other health professional schools, the VA makes an important contribution to the training of future health care providers, many of whom will spend their careers in the VA system. UCLA enjoys an affiliation with three VA medical facilities.

As does the entire health community, the VA faces some serious health challenges. Two issues that demonstrate the severe financial stress faced by the VA system are the national nurse shortage and the AIDS epidemic. Congress has attempted to support the VA's efforts in meeting these challenges by enacting authorizing legislation. For instance, P.L. 100-322, enacted in May, 1988, provides the authority for bonus pay to recruit and retain quality nursing staff. Similarly, P.L. 96-330, enacted in August, 1980, provides special salary rates for VA physicians. Unfortunately, the legislation addresses, but does not solve the VA's staffing problems. It establishes the necessary salary flexibility, but does not meet the opportunity with the necessary funds. As a result, the VA has been forced to compromise the resources in accounts for VA infrastructure needs (e.g. equipment, construction and repairs) to meet salary commitments. An increased appropriation is needed to support the programs established in recent legislation and protect the VA's infrastructure accounts from deterioration.

Over the past decade, the medical care appropriation has not included a real dollar increase. At the same time, the VA has increased the amount of care provided. Since 1980, the VA workload has increased by 60,000 inpatient treatments, 5 million outpatient visits, and 38,000 nursing home stays -- without an increase in real dollar spending.

The funding for FY-89 falls at least $600 million short of the amount needed to supply care to eligible veterans. This shortfall has stretched the VA beyond reasonable limits and forced reorganization of services. The results of working with too limited resources have brought into play ethical and moral considerations, such as timeliness and access to care. If forced to continue operating with insufficient funding, the VA will be in danger of impairing services, eroding the standards of medical care, and threatening the symbiotic relationship between academic health centers and DMS facilities. A study by staff members of this Committee concludes, "The fiscal health of the VA medical system is not good." I concur wholeheartedly with that statement.

The federal government must begin now to restore VA medical care funding to appropriate levels and to minimize the damage already experienced to the system. Further erosion will jeopardize the VA's ability to meet current responsibilities and future health care challenges. The VA medical care budget must be given careful attention and increased funding. In FY-90, the VA medical care appropriation must begin to rectify past shortfalls and also accommodate the costs of the new entitlements.

For FY-90, the Friends of the VA recommend a medical care appropriation of $12.42 billion. This recommendation is consistent with that of the Independent Budget, developed by four veterans service organizations, reflecting strong agreement among consumers of the VA health care system as to current and future requirements. A $12.42 billion funding level will allow the VA to meet the needs of those eligible for care as well as restore fiscal health to the system.

The current services funding level of $12.02 billion will restore stability and adequacy to the VA medical care system. In other words, an additional $1.5 billion over the FY-89 appropriation of $10.54 billion is necessary simply for the FY-90 appropriation to maintain the current level of effort. Personnel costs comprise approximately 60 percent of the DMS budget. A large portion of the $1.5 billion is associated with P.L. 100-322; another portion will contribute to the 4.1 percent federal employee salary increase which took effect on January 1, 1989.

Additional funding beyond $12.02 billion is necessary to correct recent actions by the VA to accommodate inadequate funding and to implement enhancements to the VA medical care system. Many of these improvements are designed to prepare the VA medical care system for the challenges of the progressively aging veteran population. The number of veterans over age 65 will increase by over 60 percent before the turn of the century. Recent studies have shown a correlation between aging, health, and income. The percentage of veterans with low incomes increases after age 55. Older veterans require more care and more costly care than other populations. The Friends of the VA Medical Care and Research request an additional $400 million to begin geriatric programs and to meet other specific areas of critical need.

To meet today's health challenges and to prepare for future medical needs of those who have served our nation, the VA must receive increased funding. The recommended level of funding will insure that veterans receive high quality medical care in a timely manner. Equally important, the Friends of the VA Medical Care and Health Research budget request of $12.42 billion will enable the VA to prepare to accommodate the needs of the aging veteran population.

The quality of care provided to veterans in VA medical centers around the country is significantly enhanced by the presence of medical, rehabilitation, and health services research programs. These programs serve to attract to the VA distinguished physician scientists who not only engage in research activities but also provide medical care to veterans. In addition, research performed in the VA by M.D. and Ph.D. scientists has lead to important discoveries regarding the diagnosis, treatment, and prevention of a number of disease and disorders. Many veterans have benefited directly from the research program, and I commend to your attention the statements made by six individuals veterans beginning on page 7 of the Friends of the VA Budget Proposal.

Research activity at the VA currently focuses on a wide range of diseases and disabilities such as AIDS, arthritis, drug and alcohol dependence, and heart disease. Adequately funded, these projects and many others have enormous potential not only to improve the health of veterans and the population at large, but also to reduce health care costs.

Last year, the Friends of the VA urged the Congress to provide a $235.6 million VA research budget in order to restore the program to its FY-85 level of effort, thereby recapturing losses sustained during the previous three fiscal years. The Congress responded by providing a $210.2 million budget -- a nine percent increase over FY-88 and a much appreciated first step toward revitalizing the VA research effort. However, the medical research program has yet to recover fully from reductions sustained between 1985 and 1988. Five hundred merit review awards will be funded during the current year, a number substantially below the 722 awards supported in FY-85.

The Friends of the VA Medical Care and Health Research recommend a total FY-90 VA research budget of $249.1 million. Funding at this level will simply continue moderate growth in the activities of the rehabilitation and health services research programs and restore the FY-85 level of effort for the medical research program. Three activities would be modestly expanded as described in our written statement. Funding at this level will strengthen the VA research program and enhance its ability to contribute significantly to the improvement of health care for veterans and the population as a whole.

The health programs administered by the VA represent our nation's commitment to those who have served this country in times of greatest need. Providing high quality care must continue to be of the highest national priority. In 1988, Congress and the President acknowledged the importance of veterans' concerns by elevating the VA to a cabinet level department. In 1989, this commitment should be continued and enhanced by providing an appropriation that will prepare the DMS to meet current and future health care challenges.

While we recognize the need for fiscal conservatism, we do not believe that it is prudent or responsible to sacrifice the success of the VA's programs in attempting to reduce the federal budget deficit. The Friends of the VA Medical Care and Health Research respectfully urge adoption of the outlined budget proposal. Thank you for the opportunity to appear before the Committee this morning.

L. Thompson Bowles, M.D., Ph.D.

February 9, 1989

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE AND STAFF:

MY NAME IS DR. L. THOMPSON BOWLES. I AM THE VICE PRESIDENT FOR MEDICAL AFFAIRS AT THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER AND A MEMBER OF THE VETERANS' ADMINISTRATION'S SPECIAL MEDICAL ADVISORY GROUP. IT HAS ALSO BEEN MY PRIVILEGE TO SERVE AS A CONSULTING THORACIC SURGEON TO THE WASHINGTON V.A. HOSPITAL AND THE MARTINSBURG V.A. HOSPITAL FOR OVER A DECADE.

THE SPECIAL MEDICAL ADVISORY GROUP IS CONCERNED ABOUT THE PRESIDENT'S BUDGET PROPOSAL FOR 1990. WITH THE INITIATIVES ENACTED IN 1988, THERE IS INSUFFICIENT SUPPORT FOR CURRENT PROGRAMS. THE PASSAGE OF P.L. 100-322, "THE VETERANS BENEFITS AND SERVICES ACT OF 1988" REQUIRES SIGNIFICANT ADDED EFFORT. A PAY INCREASE FROM 2 TO 4 PERCENT; INCREASING REQUIREMENTS FOR SPECIAL SALARY RATES; INCREASING DEMANDS FOR SERVICES BY AIDS VICTIMS IN THE VETERAN POPULATION; AND A FEDERAL EMPLOYEE HEALTH BENEFIT INCREASE ALL IMPOSE CONSIDERABLE PRESSURE ON THE CURRENT BUDGET. THE 1990 BUDGET PROPOSAL DOES NOT SUPPORT THESE INCREASED DEMANDS.

CURRENT EMPLOYMENT IN THE DEPARTMENT OF MEDICINE AND SURGERY IS 191,800. THIS NUMBER IS 3000 LESS THAN THE CONGRESSIONAL REQUIREMENT. WITHOUT A 1989 SUPPLEMENT, FURTHER REDUCTION CAN BE ANTICIPATED TO A LEVEL OF 186,000. BY MOVING FUNDS FROM OTHER ACCOUNTS, THE DMS WAS ABLE TO REMAIN NEAR THE CONGRESSIONALLY MANDATED 194,720 EMPLOYMENT LEVEL. ONLY ACTION BY THE CONGRESS CAN PROVIDE A 1989 SUPPLEMENTAL APPROPRIATION WHICH WILL PRESERVE THE MEDICAL CAPABILITY OF THE DEPARTMENT THAT YOU AND YOUR CONGRESSIONAL COLLEAGUES HAVE DETERMINED MUST BE PROVIDED FOR VETERAN'S HEALTH CARE.

V.A. HOSPITALS ALL OVER THIS NATION HAVE BEEN DELAYING NECESSARY RENOVATION AND TECHNOLOGY INSTALLATION IN ORDER TO MAINTAIN PERSONNEL AT NECESSARY LEVELS. UNLESS THIS SITUATION IS RECOGNIZED AND ADDRESSED BY THE CONGRESS, THE PATIENT CARE ENVIRONMENT CANNOT BE ADEQUATELY SUSTAINED.

NURSING PERSONNEL, MEDICAL AND X-RAY TECHNICIANS AND OTHER TECHNICAL STAFF ARE IN SHORT SUPPLY IN NEARLY ALL AREAS OF THIS COUNTRY. WITHOUT INCREASES IN SALARY SUPPORT, A GROWING NUMBER OF V.A. MEDICAL CENTERS CANNOT RECRUIT AND RETAIN ADEQUATE STAFF NUMBERS IN THESE CRITICAL AREAS.

THE SAME IS TRUE FOR PHYSICIANS. WITHOUT MAJOR INCREASES, THE DEDICATED MEDICAL PERSONNEL SERVING IN THE SYSTEM ARE LESS ABLE TO SUSTAIN THEIR FAMILIES ON THEIR INCOME IN THE V.A. SYSTEM.

IF THE PRESIDENT AND THE CONGRESS WISH TO HONOR CURRENT COMMITMENTS TO VETERANS, THE 1990 BUDGET MUST BE INCREASED TO AT LEAST $12 BILLION. THIS LEVEL WOULD SUPPORT A BALANCED PROGRAM INVOLVING THE MANDATED NUMBER OF 194,720 FTEE.

WITHOUT SUCH AN INCREASE, THE CONGRESS SHOULD RE-EXAMINE THE LEGAL COMMITMENTS TO CARE WHICH ARE CURRENTLY ON THE STATUTES. EITHER PROGRAMS OR ELIGIBILITY FOR CARE MUST BE CONSTRAINED OR CUT. IT IS SMAG'S POSITION THAT THE COUNTRY IS OBLIGATED TO PROVIDE ITS VETERANS WITH THE SERVICES DESCRIBED IN OUR CURRENT LAWS AND, AS SUCH, SHOULD PROVIDE THE ADDITIONAL $1.3 BILLION OVER THE PRESIDENT'S 1990 BUDGET PROPOSAL.

IT HAS BEEN MY PRIVILEGE TO SERVE AS A SURGICAL CONSULTANT TO TWO VETERANS HOSPITALS DURING THE PAST DECADE. THE COMPETENCE AND DEDICATION OF STAFF MEMBERS HAS BEEN IN EVERY WAY EXEMPLARY. HOWEVER, I DO NOT BELIEVE THESE INSTITUTIONS CAN CONTINUALLY MANIPULATE THEIR CAPITAL BUDGETS TO OFFSET INADEQUATE SUPPORT FOR SERVICES. IF THE CONGRESS LEGISLATES AN INCREASE IN SERVICES, IT MUST PROVIDE THE PROGRAMMATIC SUPPORT FOR THESE INITIATIVES.

MR. CHAIRMAN, THANK YOU FOR THE PRIVILEGE OF ADDRESSING YOU THIS MORNING.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

VETERANS AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

on

FY 1990 VA BUDGET RECOMMENDATIONS FOR VETERANS BENEFITS AND SERVICES

FEBRUARY 9, 1989

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 9, 1989

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to set forth its views on the proposed funding for the Veterans Administration for FY 1990 following an initial appraisal of the budget submitted to Congress by the Reagan Administration.

The previous Administration proposed for the Veterans Administration, budget authority of $30 billion to fund medical, compensation, and other programs for the nation's 27.3 million veterans, eligible members of their families, and survivors of deceased veterans.

Included in the total is an appropriation request for $28.6 billion, a net amount of $84 million related to proposed legislation and $1.4 million in permanent authorizations and offsetting receipts. The actual appropriations request is an increase of $193 million over funds appropriated for FY 1989.

While the proposed increase in funding appears to have some positive points, there are a number of ill-considered proposals incorporated into the structure of this budget, and each of them will be addressed in detail later in this statement.

At the outset Mr. Chairman, we believe it necessary to reiterate The American Legion's long-standing position on the funding of veterans benefits and programs. The organization has a total commitment to the health and well-being of this nation's veterans, and therefore, stands for full funding for veterans programs. By that we mean there should be the provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all of those programs. Each of them had a purpose when enacted, and each has been proven as currently meeting a legitimate need of the veteran population. We are aware of no programs at present that are superfluous or redundant.

The American Legion feels it is imperative to note that the VA budget was only 2.5 percent of the total Federal budget in FY 1989. A point that has never been made by critics of adequate resources for veterans is that if the entire budget of the government had progressed at the same rate as the VA's, there would now be a surplus rather than a raging deficit.

Veterans who receive VA benefits have earned them - and they deserve them. As citizens first, and veterans second, we appreciate the ongoing attention to the legitimate needs of veterans who are less fortunate than some of their fellow comrades.

It seems that with each new budget comes new and innovative methods by which to whittle away veterans programs. The American Legion opposes any further reduction of veterans benefits. Thus, The American Legion is grateful that the Congress, under guidance and counsel of the Veterans Affairs Committees, maintains a high level of responsibility in the formulation of the VA budget.

Before providing comment on specific budget items, which will be done for the most part with reference to the departments of the VA that administer them, we shall first address the legislative proposals set forth in the budget message. These represent a miscellany of ideas, old and new, some of which seem to totally ignore the anticipated demand for essential benefits and services.

LEGISLATIVE INITIATIVES

# The Veterans Administration recommends a cost-of-living adjustment of 3.6 percent, effective December 1, 1989. The position of The American Legion is that these COLAs should be consistent with increases in the Consumer Price Index. The proposed 3.6 percent increase for those disabled in or due to service - the most deserving of all Federal beneficiaries - appears to be commensurate with the current rate of inflation.

# The budget proposal contains a recurring legislative initiative that calls for a change in the eligibility for the plot allowance so as to make it consistent with the eligibility requirements for the basic burial allowance. The American Legion has consistently stated that Congress made a serious mistake when it restricted the criteria for the burial allowance. We are mandated not only to oppose this legislation but, in light of considerable increases in the cost of burial plots, to also seek an increase in the plot allowance to $250.00.

# A proposal relating to readjustment benefits would increase dependents education assistance allowances and vocational rehabilitation subsistence allowance by 5 percent, effective January 1, 1990. The American Legion supports this proposal. We believe that adjustments in these rates have not kept pace with rising costs of education and training.

# Another proposal relating to dental care would permit dental treatment on an outpatient basis, rather than on an inpatient basis to veterans who are scheduled to receive certain hospital treatment. This proposal seems reasonable as the veteran could be treated as an outpatient and remain home until the scheduled hospitalization. This

would help reduce hospital costs and make more effective use of hospital resources.

#The Reagan Administration's Federal Credit Reform Proposal would require that agencies issuing Federal credit bear the costs of the grant equivalent subsidies provided through credit programs. According to the information contained in the budget message, a grant equivalent subsidy occurs whenever the government provides credit to borrowers on more favorable terms than those available in the private sector. The proposal would require that the VA make payments to the U.S. Treasury in the amount of the subsidy prior to the issuance of a vocational rehabilitation loan. Loans of up to $620 are available to service-connected disabled veterans enrolled in vocational rehabilitation programs as provided under Chapter 31 of title 38, USC, when, in the opinion of the rehabilitation counselor, the veteran is temporarily in need of additional financial assistance. Repayment is made in ten monthly installments, without interest, through deductions from future payments of compensation, pension, subsistence allowance, educational assistance allowance, or retirement pay. Therefore, repayment of the loan is virtually guaranteed. We see two problems with this proposal.

The initial problem is that the Treasury could conceivably be empowered with the authority to impose policy on the Veterans Administration with respect to the operation of the vocational rehabilitation loan program. In addition, the figures involved, as in the current budget proposal, distort the VA budget. It gives the appearance of additional funding for veterans, but it does not effect veterans whatsoever. Therefore, we do not support this proposal.

#Another proposal would repeal the authority that permits the VA to make educational loans. This is a recurrent proposal The American Legion has consistently opposed. As we previously stated, as a cost savings measure, the Omnibus Budget Reconciliation Act of 1981, limited the number of individuals eligible for VA education loans. Those who retain eligibility and depend on these loans could be forced to discontinue their program of education or training. The American Legion continues to oppose this proposal.

# Proposed legislation would require veterans without service-connected disabilities who are in the middle or higher income categories (Categories B, and C) to make a nominal co-payment per outpatient visit and for prescriptions; and to make a nominal per diem payment for inpatient treatment. It authorizes reimbursement from third party health insurers for treatment of nonservice-connected disabilities, of insured veterans who have relatively minor service-connected disabilities (0 to 20 percent). These charges are analogous to Medicare part B copayments.

The American Legion is totally opposed to this legislation. The organization is mandated to oppose the Means Test and any expansion thereof. This program is not and has never been cost-effective. The shortfall in medical care funding that currently exists has already led to an almost total restriction on treatment for Category B and C veterans. The subsequent reduction in workload is being used as the rationale for the decreased funding levels in the FY 1990 proposal.

This is a total disgrace. The American Legion continues to oppose third party reimbursement as it currently exists, and we certainly oppose its application to service-connected veterans.

DEPARTMENT OF VETERANS BENEFITS

Of the Veterans Administration's total budget request for FY 1990, almost 57% or $16.268 billion will be allocated to the payment of direct benefits to veterans, dependents, and survivors. As statutory entitlements, these benefits must be funded. Their purpose is to provide compensation for service related disability and death, nonservice-connected disability and death pension benefits, educational subsistence allowances, and burial benefits.

These direct benefit programs are administered by the Department of Veterans Benefits (DVB) through 59 regional offices located in the 50 United States, the District of Columbia, the Commonwealth of Puerto Rico, and the Philippines. Funding for employment under the FY 1990 budget request is $548.8 million. This will require a 4.4% reduction in overall employment in the Department of Veterans Benefits from 12,650 to 12,100 FTEE, a decrease of 550. The current budget request calls for losses of 48 FTEE in Executive Direction; 91 in Veterans Assistance Service; 7 in Compensation, Pension and Education; 45 in Loan Guaranty; 5 in Vocational Rehabilitation and Counseling; 19 in Insurance; and 355 FTEE in Support Services.

A major portion of this reduction involves the one-time transfer of budget responsibility for 227 FTEE from the Department of Veterans Benefits to the Department of Medicine and Surgery (DM&S) resulting in a net payroll decrease of $500,000. This results from the termination of the "common services" reimbursement agreement between DVB and DM&S covering the activities of certain DVB personnel assigned to medical and regional office centers (VAMROCs). Additionally, the reduction of 7 FTEE in the Compensation, Pension and Education Service staffing reflects the organizational transfer of the Presidential Memorial Certificate Program and related personnel from the Compensation, Pension and Education Service to the Department of Memorial Affairs.

The cited basis for the reduced employment levels within the Department of Veterans Benefits for FY 1990, over and above the indicated transfers, is declining workloads and savings attributable to modernization initiatives, according to the budget summary.

Mr. Chairman, The American Legion continues to be supportive of economy of personnel in management, and maximum productivity by all Federal employees. However, it must be recognized that although the Veterans Administration as a whole, and the Department of Veterans Benefits in particular, is heavily dependent upon its automatic data processing systems to accomplish its mission of processing tens of thousands of claims and the timely payment of benefits due, a certain number of trained personnel are still required to properly process and adjudicate cases. Despite the projections of productivity improvements and declining workloads, there currently exist within DVB field stations mounting backlogs. The more complex an issue is in a claim, the more man-hours required to develop and adjudicate each case.

The complexity of veterans claims has increased in part due to issues such as the pathology of post-traumatic stress disorder (PTSD), the possible health effects related to exposure to Agent Orange and new provisions relating to cases based on ionizing radiation, just to name a few. Within the past year, additional due process procedures have been implemented in the Veterans Administration as a result of court and legislative action. Quality rather than quantity must be the most important standard in VA operations.

It must be pointed out that the proposed reductions in current employment will most directly affect the activities of the DVB field stations. If enacted, the level of employment in the Department of Veterans Benefits will have been reduced by more than 6,000 FTEE since 1979. It appears that slightly more than half of the proposed reduction of 550 FTEE involves a shift of budgetary responsibility for certain "common services" personnel which will not materially change the work currently performed by such personnel in the VAMROCs. The American Legion remains deeply concerned by the cumulative effect that consistent and persistent losses have had and are continuing to have upon the individual field stations. Although there have been no formal reductions in force, attrition through transfers to other agencies, resignations, and retirements, without replacements have been the methods by which mandated staffing reductions have been met. This process, while achieving the intended administrative budgetary goals, does not affect such reductions in a coherent or uniform manner. The net result has been that some stations have lost a disproportionately large number of experienced and trained personnel from the adjudication, administrative, and support divisions.

The workload in the field stations over this same period, however, has not undergone a substantial decrease. There are fewer total personnel available to do the essential work required. This involves everything from pulling claims folders from file cabinets, to answering claimants' correspondence and phone calls, rating medical evidence, preparing an award for payment, etc. Thus, backlogs in claims processing and correspondence have continued to grow. According to the budget summary information, quality and timeliness in claims processing and the delivery of benefits and services to veterans and their survivors has deteriorated. Productivity has likewise declined with an increasing number of "marginally efficient stations" noted. However, the summary goes on to state, "The cumulative effect is to lower program productivity, but this will be corrected through the 1990 proposed level." The American Legion is not assured that given the declining personnel resources; the existing heavy backlogs; problems of timeliness, quality and productivity; and current ADP hardware resources, the projected goals of the FY 1990 budget request can be met.

The impact of overall declining staffing levels in DVB field stations is graphically illustrated by steady increases in the processing times for almost all categories of benefit claims. According to available data, the field stations in FY 1986 were able to complete processing in 34.9% of their compensation claims in 90 days or less. In FY 1987, this had dropped to 30.7% and by FY 1988, it was down to 27.5%. In FY 1986, 54.9% of the pension cases were completed within 90 days. In FY 1987, 53.0% and in FY 1988, 49.9%. Claims for dependency and indemnity compensation (DIC) completed within the 90 day standard in FY 1986 stood at 64.6%. In FY 1987, this had declined to 60.1% and by FY 1988, it had fallen to 57.4%. The budget summary acknowledges that as of January 1, 1988, of the 28 standards in the Compensation and Pension Timeliness Measurement System, an acceptable level of timeliness was being met in only 5 of these standards. Two years prior, acceptable levels of timeliness were being met in 18 of 26 standards. This problem is further aggravated by the fact that about 20% of the adjudicators in the field stations are trainees, as compared with 12.4% two years ago. The number of trainee development clerks is estimated to be even higher.

The American Legion is also concerned by the continued deterioration in the quality of claims processing as reflected by an increasing error rate in both rating and authorization actions, over the past three years. This is despite the fact that these problems have been acknowledged in previous DVB budget requests. The proposed reduced funding and staffing levels were stated to be sufficient to affect a reversal of the downward trend within the budget period and improve the quality of the decision-making process. No such improvements have been realized, according to the DVB's own data. Rather, the trend reflects continued delay and a perceptible increase in the error rates. The current DVB budget request makes similar promises of improved timeliness and quality, based on reduced staffing.

Mr. Chairman, The American Legion is pleased, however, to note the inclusion of a request for $921,000 for the establishment of an Adjudication Academy for the purpose of training new adjudicators. We express strong support for this initiative. As previously noted, there is a significant percentage of trainees in the field stations. Centralizing and formalizing the training activity should result in an improvement in the overall quality of decision-making in the adjudication process. While this training academy will not impact upon the field stations' backlogs or quality overnight, it is a necessary step toward slowing and hopefully reversing the downward trends in quality and service of the last several years.

Despite the projection of a decline in the total number of claims filed, we believe there will be a significantly increased workload associated with the additional due process provisions contained in the consent decree issued in the litigation Semanchuk vs. Walters and the "Veterans' Judicial Review Act/Veterans' Benefits Improvement Act of 1988" - PL 100-687. These requirements increase the overall processing time of an individual claim, thereby contributing to the existing backlog. The establishment of the Hearing Officer position to conduct personal hearings at the field stations is not estimated to result in savings in FTEE. Thirty-six Hearing Officers have been appointed with two additional planned. Staffing for these positions has been drawn from current adjudication personnel in the field stations. The work previously performed by these rating specialists, who were the most experienced and productive, is to be assumed by rating board members who are no longer required to conduct or participate in personal hearings. Access to the new Court of Veterans Appeals should likewise increase the number of cases requiring appellate development.

One of the most often cited examples of a declining workload is the current education program for Vietnam Era veterans wherein the number of veterans eligible and enrolled has dropped sharply in recent years. In addition, the program will terminate on December 31, 1989. This favorable set of circumstances should theoretically enable field station directors to reassign adjudication and authorization staff to other types of cases as the program phases out. This scenario, however, overlooks the fact that PL 98-525 authorized new education programs and the overall caseload in both the Education

Service and the Vocational Rehabilitation and Counseling Service has begun a phase of long-term substantial growth. While the number of participants under Chapter 32, the Post-Vietnam Era Veterans' Educational Assistance Program has peaked and has begun to gradually decline, this will be more than offset by the increased activity in the Montgomery GI Bill Educational Assistance Programs for veterans, servicepersons, and members of the Selected Reserve in FY 1990 and beyond. The current number of veteran participants in 1989 is estimated to be 13,800 and the number of active duty participants is estimated to be 12,000. In 1990, the number of veteran participants is projected to more than double to 34,100 and active duty participants will more than quadruple to 44,500. The Selected Reserve Educational Assistance Program is also expected to undergo substantial growth during the same period. It has risen from 72,846 in 1988 to an estimated 117,100 in FY 1990.

Mr. Chairman, The American Legion remains concerned that the field operations of the Department of Veterans Benefits under current staffing levels cannot process the current workload in a reasonable, timely, and efficient manner.

There are also several other factors which we believe have a direct and immediate impact upon field station workloads that are not clearly addressed in this budget proposal. On January 19, 1988 veteran status was granted to former members of the Merchant Marine. This group numbers 80,000-90,000 and they are now eligible for the full range of benefits and services enjoyed by other war veterans. Processing of applications for discharge certificates by the Coast Guard has been slow up to this point which has delayed the submittal of many benefit claims by these individuals. We would expect the number of claims received in DVB field stations to increase appreciably in the months to come.

We would also like to comment upon the proposed decrease in employment of 167 FTEE predicated upon the implementation of several short-term initiatives under DVB's Twelve Point Plan for modernization. The two programs most directly affected by these staffing reductions will be Veterans Assistance Service which provides benefit information, advice, and assistance to veterans, dependents and their survivors, and the Support Services program which is responsible for financial management, general administrative, and personnel management in the field stations. The American Legion is supportive of the concept of DVB's modernization plan. Various new and ongoing initiatives under this program are supposed to improve internal operations within these programs so as to justify the indicated personnel savings to be effected. However, DVB, under the budget requested for modernization and the short-term improvements to be undertaken or completed during FY 1990, has not satisfactorily addressed the continuing overall problem of productivity and timeliness in claims processing, in our judgment. Given the age and limited capacity of DVB's ADP equipment including the TARGET System, the timely modernization of the entire ADP system is imperative. The ultimate goal of the current program is to improve the efficiency and quality of the claims processing activities in the field stations, thereby achieving savings in staffing and resources. Claimants will also directly benefit as a result of having their claims handled more expeditiously. It is, therefore, not at all clear how the current "bare bones" approach to modernization can be expected to produce the projected personnel savings cited in the budget proposal and at the same time provide veterans and other claimants improved service and assistance.

We believe an obvious conclusion can be drawn with regard to the impact of the continued decline in staffing levels in the field stations under past budgets as well as the current budget proposal. It is apparent that DVB's overall ability to deliver benefits and services in an efficient, accurate, and timely manner has been compromised. The problem has reached serious proportions, particularly in the compensation, pension and education programs, in our opinion. There is no doubt that the eventual introduction of new technology and ADP equipment and software systems will greatly enhance field station operations. However, we hasten to note that current efforts in support of the modernization program are focused in some instances on areas outside the direct benefit programs and have essentially left a number of critical problems unaddressed and unresolved.

The American Legion is convinced that the Department of Veterans Benefits cannot operate efficiently or effectively at the projected employment levels.

DEPARTMENT OF MEDICINE AND SURGERY

It has long been the position of The American Legion that the Veterans Administration medical care budget must be maintained at sufficient levels to ensure the provision of high quality patient care to all eligible veterans who apply for such service. This position was recently reaffirmed by Delegates to The American Legion's 70th National Convention in Louisville, Kentucky, who approved Resolution No. 453 - "Oppose Further Curtailment of Veterans Administration Health Care Benefits for Veterans." This resolution calls for the Legion to petition the President and Congress: 1) not to limit the eligibility of the nation's veterans for VA health care benefits; and 2) to provide adequate funding to the VA to enable it to continue to offer "state of the art" medical care to those veterans who are eligible for, and need to apply for, such care.

Resolution No. 453 also expresses the Legion's opposition to "any and all efforts to restrict, curtail, or to eliminate the entitlement of honorably discharged veterans to health care from the VA, wherever and whenever such care is needed and applied for by such veterans."

We believe, Mr. Chairman, that the intent of Resolution No. 453 is sound and is based on a fair sense of reciprocity. Today, throughout the Veterans Administration health care system, not all medical centers are able to provide the highest quality of care to all eligible veterans.

Unfortunately, those VA health care facilities reporting an adequate financial picture today are the exception rather than the rule. Today, a major differentiation between entitled and eligible veterans is used in determining who receives care and who does not. The American Legion finds it difficult to believe that it is the expressed intent of the Congress that veterans who are not determined by means test criteria to be Category A veterans should be administratively disposed of and not receive necessary health care, as is now occurring. In a recently conducted survey of all VA medical centers initiated by The American Legion it has been found that roughly eighty percent (80%) of all VA medical centers have already begun to severely curtail inpatient and outpatient services to Category B and C veterans and even to nonservice-connected Category A veterans. When analysis of our survey is completed, we will be happy to provide the Committee with our findings.

Now that this rationing of health care has begun it will be difficult to reverse the process without the provision of necessary resources.

The proposed FY 1990 medical care budget proposes a net increase of only $185.8 million above the FY 1989 level. We have learned during a previous hearing before this Committee in September 1988, that the Veterans Administration health care budget for FY 1989 is experiencing a serious shortfall of between $600 million to $1 billion in order to maintain workload totals realized during Fiscal Years 1987-1988. Without the infusion of necessary dollars, which would only help to alleviate cumulative problems developed over many previous years, the Veterans Administration will have to enforce the letter of the law with regard to which veterans receive health core services and which do not. Unfortunately, this situation already exists, as mentioned a moment ago.

As we review the FY 1990 budget proposal submitted by the Reagan Administration, we can acknowledge some positive developments. Overall, a greater concentration of resources will be focused on VA nursing home programs and in ambulatory care activities. Additionally, a greater concentration of resources will be applied to the AIDS Clinical Program, to Post-Traumatic Stress Disorder (PTSD) Programs, and to the VA Learning Opportunities Residency (VALOR) Program. Also, funding is proposed to accomplish a myriad of facility activations and to continue a strong VA academic affiliation effort.

Where we are dismayed, however, is in the fact that in order to accomplish what few positive developments we can ascertain from the proposed FY 1990 budget, these accomplishments will come about not from new funding sources, but rather from a redistribution of resources from among existing programs. Once again, we do not believe that Veterans Administration officials have been totally candid as to the true fiscal requirements of the Department, with respect to medical care programs.

We applaud the proposed increases for VA extended care programs, but object to proposed reductions in VA hospital activities. Likewise, we welcome a greater concentration of resources in ambulatory care activities, as well as other previously mentioned programs. However, we must object to the mandated one-percent (1%) productivity increase, decreases in domiciliary and community nursing home care services, A-76 privatization savings, nursing realignment savings, and other proposed reductions (including a decrease in employment levels of 5,923 FTEE) all of which will lead to a further diminution in the quality of services being provided.

Through surveys of VA medical centers conducted by our National Field Representatives, and through information obtained over the past two months in our own independent survey of all VA medical centers, we have come to learn first-hand that serious funding problems exist in a majority of VA health care facilities. A synopsis of comments provided by VA medical center officials to our recent hospital survey is hereby provided so that these poignant views may be considered by this Committee during its budget deliberations:

o Reduced discretionary workloads will not result in substantial budgetary savings.

o VA policy makers are avoiding the most significant issue: the VA health care budget is seriously under-funded if the VA is to maintain current services in a quality manner.

o Use of non-recurring maintenance money for other purposes has been and is expected to be depended upon for fiscal survival.

o Patient complaints are increasing as services are curtailed. Longer appointment waiting times are occurring for all categories of veterans.

o The salary structure for VA health care professionals needs to be overhauled if the VA is to become competitive in its recruitment endeavors.

o Mandatory workloads are being increasingly delayed for special procedures, i.e., orthopedic surgery, and prostheses. Also, necessary drugs, supplies and equipment purchases are being deferred. Routine equipment replacements are postponed longer than is reasonable.

o Category B/C and Category A nonservice-connected veterans cannot obtain outpatient services, and limited inpatient services from VA medical facilities.

o Contract nursing home expenditures are being drastically reduced. Six month contracts are systematically being reduced from one to three months.

o Over-the-counter drug prescriptions are being severely curtailed for the non-discretionary workload, while pharmacy drug formularies are being drastically reduced, for both service-connected and nonservice-connected clientele.

Mr. Chairman, it is apparent that a specific pattern is emerging with regard to VA health care. It is true that veterans who are entitled by law to receive VA health services are, in most cases, receiving care. We cannot say assuredly that in all cases entitled veterans are receiving quality health care services because this statement would imply that there are no staffing problems, that all veterans are in fact seen in clinics in a timely manner, that treatment outcome is in fact comparable to private sector averages, and that veterans health care requirements are being met with the latest innovations in diagnostic and treatment technology.

There were a number of statements made to this Committee in September 1988 by VA field level management personnel, alluding to the seriousness of the VA medical care funding inadequacies. These have not disappeared. It does appear, however, that VA officials in responsible positions have chosen to enforce constraints on veteran eligibility for VA health care services as a management tool in dealing with the reported budgetary shortfalls.

We strongly object to the use of accounting techniques to portray an overall increase from year to year in the VA medical care budget. It appears that the FY 1990 medical care budget proposal, on the surface, may be sufficient to the needs of the Department. A closer analysis of the language used within the proposed FY 1990 budget only confirms that many deserving veterans will be turned away from the VA. The projected workload totals propose a modest increase in outpatient visits. The truth of the matter is that older, sicker veterans will consume a greater percentage of VA resources and that more veterans will be denied care during FY 1990 than in any previous year.

As National Commander H.F. "Sparky" Gierke stated before this Committee in

September 1988, we are now at a crossroads, and some serious decisions are going to have to be made as to whether the VA medical care system is going to be allowed to continue to erode through decremental funding, or whether adequate funding will be provided to allow the system to give first-class medical care to veterans.

Medical and Prosthetic Research

The budget authority requested for FY 1990 is $197.3 million, which is a decrease of $12.9 million from the FY 1989 level. Total average employment for FY 1990 is 4,106 FTEE. This is a decrease of 616 FTEE from FY 1989.

Not described in the budget document is an additional $8.0 million that must be reduced to support increases in general program funding such as normal payroll increases, the annualization of the January 1989 4.1% pay raise, and inflation. This brings the net reduction for this account to $20.9 million.

The American Legion strongly opposes these proposed decreases. It should be noted, as described in the budget document this appropriation provides funding for program activities in the following areas:

Medical Research: Efforts in this area fall into two broad categories: research on medical, dental and psychiatric problems that are specific to the veteran population (spinal cord injury, Agent Orange, etc.); and research on general health problems that are particularly prevalent among veterans (e.g., alcoholism, aging and schizophrenia). Most of the investigators are VA clinicians and the close links between the research and patient care functions give the research program a clinical orientation that is directly related to its goal of providing quality medical care to the veteran-patient.

This program is designated to receive the largest reductions in appropriations and FTEE. The budget request will provide only $175 million and 3,661 FTEE. This is a decrease of $31.9 million and 603 FTEE from FY 1989.

It is estimated between 2,400 and 2,500 research projects will be active in FY 1989. The average cost of each project is $82,000 and the length of each project requires between three to five years to complete. Due to the requested FY 1990 funding level, there will be no new projects begun in FY 1990 and at least 368 ongoing projects will have to be prematurely terminated. This number is based upon the average cost per project that must be reduced in order to meet the proposed appropriation level. As we previously stated the proposed funding is inadequate. Of great concern is the termination of ongoing projects for which staffing, equipment, and space have already been provided and most importantly, where research activities have already been initiated.

Rehabilitation Research: This program focuses directly on the needs of the veteran who is functionally impaired as a result of amputation, paralysis or the loss or impairment of his or her vision, hearing or speech. The latest computer and other technological advances are used to develop devices, techniques and concepts in rehabilitation that will minimize the disability and promote functional independence among disabled veterans.

The budget request will provide $18.9 million and 245 FTEE. This is a decrease of $150,000 and 15 FTEE from FY 1989. The FY 1990 funding estimate is the same as the FY 1989 appropriation level. Five programs will be reduced to support increases in general program funding such as normal payroll increases, annualization of the January 1989 pay raise, and inflation.

Health Services Research: The goal of this research is to improve the effectiveness and efficiency of the Veterans Administration's health care delivery system. Health services researchers develop and disseminate information designed to help clinicians, investigators and administrators select medical interventions and administrative actions that are most appropriate to the Agency's mission, which is the provision of quality medical care services to the veteran patient.

The budget request will provide $9.3 million and 200 FTEE. The FY 1990 request is the same as the FY 1989 appropriation level with an increase in average employment of 2 FTEE. Five investigator-initiated projects will be reduced to support increases in general program funding such as normal payroll increases, annualization of the January 1989 pay raise, and inflation.

The Veterans Administration's Medical and Prosthetic Research Program is a matter of particular interest to The American Legion, as a result of our sensitivity to the importance of research in the triad of the VA health care program: clinical care, education of health manpower, and research. These three functions cannot thrive independently - the presence of the other two is required. It would be impossible for the Veterans Administration to continue the provision of high quality medical care without a strongly funded research program. As this Committee knows, much of the research in which VA engages is basic research that is advantageous not only to veterans, but is of direct benefit to all mankind. Equally as important is the fact that a strong research program ensures the recruitment and retention of high quality physicians into VA service. The Federal Government could make no wiser an investment than ensuring a vigorous and viable VA research program that benefits the entire American people.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The grant program assists the States in acquiring or constructing State home facilities for the furnishing of domiciliary, nursing home, or hospital care to veterans. Public Law 99-576, approved October 28, 1986, extended authorization for this program through September 30, 1989. Legislation has been proposed to extend the program's authorization through September 30, 1994 and clarify the State home grant award procedures.

For the second year in a row the VA budget request for grants for construction of State extended care facilities is $42 million. Based upon the priority list of applications pending approval and subject to change upon establishment of the next priority list, the FY 1990 appropriation request of $42 million will provide for six projects which will produce 760 nursing home beds and 326 domiciliary beds.

The American Legion is extremely aware of the importance of the services provided by State homes, in that they have substantially reduced the burden that otherwise would have been borne by the Veterans Administration.

An additional $7 million is requested to support workload changes in the State home program in FY 1990. This funding will support the expected increase in the nursing home and domiciliary census. Public Law 100-322 amended title 38 to authorize the VA to increase State veteran home per diem rates annually by a percentage not greater than the percentage increase in the cost of care in VA hospitals. In FY 1990, the estimated rate increases for State home programs will require $6.25 million.

The American Legion considers this program a wise investment, and when considering the ongoing efforts to reduce Federal spending, the role of the State homes is even more significant. As we move into a period of an aging veteran population, the States can be of major assistance to the Federal Government in the care for the aging veteran population through State extended care facilities. In order to materially ease the fiscal pressure on the VA, adequate funding must be provided to the States so that proposed projects may be completed.

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

The budget message provides a grant of $500 thousand to the Veterans Memorial Hospital in Manila to replace and upgrade equipment and to rehabilitate the plant and facilities. This grant has been made by the United States consistently since the end of World War II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during WWII. There is certainly an obligation by this country to continue to show our gratitude and concern for them. The American Legion continues its support for this grant.

CONSTRUCTION PROGRAMS

The FY 1990 budget proposal of $487.6 million reflects an overall decrease of $13 million from the FY 1989 budget.

Replacement and modernization of existing facilities is funded at $183 million for FY 1990. This represents an increase of $41 million from the current year. Other improvements which are not identified are funded at $219.8 million which reflects an increase of $26.9 million from FY 1989.

The FY 1990 major construction proposal recommends obligating $53.7 million for the modernization of the Newington, CT medical center; continued funding in the amount of $17.2 million for major environmental improvements to patient and nursing home care buildings at the North Chicago, IL medical center; and to obligate $112 million for the construction of a new medical center in West Palm Beach, FL. We are appreciative of these proposals and can attest to their priority.

We also support the initial proposal to provide $9.3 million in design funds for a Joint DVA/Air Force Venture Medical Center at the Nellis Air Force Base in Las Vegas, NV. We applaud a myriad of proposals for necessary building renovations, structural seismic corrections, asbestos abatement, fire and safety improvements, and clinical improvements.

As we have commented on previous occasions before this Committee, construction priorities of the VA should closely reflect the grassroots planning proposals emanating from the Medical District Initiated Program Planning (MEDIPP) process. We believe the medical construction budget should encompass all of the related health care requirements on a prioritized basis.

Offsetting the foregoing funding increases are proposed funding reductions in activities which The American Legion must oppose. We note proposed reductions in certain construction categories from the preceding year. The FY 1990 budget reflects a loss of $41.5 million in nursing home care, $32 million in domiciliaries, $18.9 million in the Parking Garage Revolving Fund and $58 million in environmental improvements in patient and nursing home care buildings.

The major construction program is proposed to receive $365.8 million in new budget authority, which represents a decrease of $2 million from the FY 1989 authorization. Additionally, the minor construction program is proposed to receive $114.7 million, representing approximately a $9 million reduction from the previous year's level. The bottom line is that the overall FY 1990 budget proposal will be lower than in each of the preceding three fiscal years. More needs are going unmet or underfunded from year to year than are corrected. This situation can be alleviated only by proper funding of all activities.

While the FY 1990 budget proposal does address some serious problems, it does so at the expense of providing for proper care of a rapidly aging veteran population which will need longer and more intensive hospital care, nursing home care, and expanded domiciliary space.

Upon review of the status of the Outpatient Care Satellite Clinics Program, the FY 1990 budget proposal indicates that five clinics will be activated. Nine (9) awards are intended for FY 1990. Of concern to The American Legion is that funding shortfalls may delay the activation of the five clinics. At a time when more emphasis is being placed on ambulatory care, as a result of new medical treatment procedures, and an emphasis on cost containment, this program must be appropriately funded to allow ongoing and accessible quality care for our nation's veterans. We will continue to monitor this situation and apprise the Committee of our findings.

Central to the VA development of effective needs identification, and planned implementations for meeting those needs, is the "Facility Development Planning Process." The American Legion generally supports the concept of the FDP in that it identifies both short and long-term needs of the VA. The program, if followed, allows for effective and timely budgeting of new construction as well as replacement and modernization of existing facilities. The program identifies needs and specific strategies necessary to accomplish these objectives. The program will provide a cost effective tool for the VA to meet its obligations and to further present budget requests which will reflect an objective basis for increased funding requirements.

A cornerstone of the FDP is the Capital Facilities study. With this system, the VA has clearly demonstrated the need for renovation or modernization of 52.3% of its medical center physical plants.

The FDP provides a methodical approach allowing for recognition of both short and long-term needs and viable solutions to these needs.

It is a goal of The American Legion to ensure that top quality medical care is provided to all eligible veterans. To achieve this, Congressional support must be continued to maintain the capital plant of the VA medical system. Adequate funding must be authorized and appropriated to upgrade and replace existing facilities. Meeting the diverse and increasing needs of aging veterans in conjunction with its other obligations presents a serious challenge to the Department of Medicine and Surgery. The ability to meet these challenges continues to be severely constrained by budgetary shortfalls. You may be assured that The American Legion will continue to closely monitor ongoing renovation and replacement projects, and other construction, both major and minor. As is our present practice, we will continue to provide copies of our site visit reports to the Veterans Affairs Committees. These reports contain information on the progress of ongoing construction as well as construction needs that are identified at specific VA medical care facilities.

DEPARTMENT OF MEMORIAL AFFAIRS

The FY 1990 budget proposal reflects a net increase of $3,195,000 and 35 FTEE over the current fiscal year.

This increase provides for the addition of two cemeteries to the National Cemetery System, growing workload at existing cemeteries, the transfer of the Presidential Memorial Certificate program to the Department of Memorial Affairs, salary increases, maintenance projects, and equipment purchases.

In PL 99-576, Congress directed the VA to conduct a study of the National Cemetery System, including a list of 10 locations where the need for additional cemeteries is greatest. While 10 locations were identified, no funding has been provided for construction as of this time.

The State Cemetery Grant Program was authorized by PL 95-476, to aid States in the establishment, expansion and improvement of veterans cemeteries. Funding in the 1990 budget proposal reflects a $4.6 million decrease in this program. The primary purpose of the program is to assist the States to provide gravesites for veterans in those areas where national cemeteries cannot fully satisfy the burial needs of veterans. The program is intended to complement the National Cemetery System. The VA provides up to 50% of the costs associated with the development, expansion or improvement mentioned above.

VA HOME LOAN PROGRAM

The VA Home Loan Guaranty program has served almost thirteen million veterans since its enactment. While the solvency of the program is perhaps our most challenging problem, we look forward to working with this Committee towards a solution which is both equitable and fair to veterans and taxpayers.

We appreciate the Administration's concern for the increasing costs of the Loan Guaranty Revolving Fund; however, we are not convinced that the measures outlined in their legislative initiatives are the best means for solving the problem.

The Reagan Administration suggests increasing and making permanent the loan guaranty funding fee from 1% to 3.8%. The VA loan guaranty program was always intended to be a benefit to eligible veterans. The American Legion continues to view the funding fee as an unfair tax on a program intended to be a benefit. To now suggest that this funding fee should be almost quadrupled is certainly not in the best interest of veterans. Possibly the fee increase may drive veterans away from the home loan guaranty program. We do not feel this is the intent of the previous Administration, Congress, or this Committee.

Near the end of the 100th Congress, this very Committee introduced a bill which passed the House by a large majority addressing the problem of insolvency while providing some indemnity to veterans. We supported that bill and hope a similar bill will be introduced in the 101st Congress.

The budget proposal also seeks a change in the law to repeal VA authority to establish maximum rates and allow the borrower to negotiate a rate with a lender on a guaranteed loan. Traditionally, the interest rate on any loan over and above a reasonable return on investment is a reflection of the degree of risk assumed by the lender. Thus, the greater the risk, the higher the interest rate. Lenders normally will not negotiate interest rates that are very much lower than the current market rate. We do not feel the elimination of maximum interest rates established by the VA will have a positive impact on the program.

The proposal recommends credit reform requiring subsidy payments to the Treasury in an appropriated amount of $833 million. The American Legion continues to oppose this measure. The Administration has calculated the dollar amount of the benefit and is asking that the money be transferred to the Treasury. Presumably this "fund" will replace the Loan Guaranty Revolving Fund and all similar funds as the source of revenue to settle claims, manage property, and acquire homes.

This proposal, however, raises several questions. What authority would the Treasury have over program policy under this proposal? It is possible that the Treasury could end up dictating policy to the VA, which is an unacceptable situation in our view. We believe this initiative is an effort by the Office of Management and Budget to eliminate all federal credit programs by those who believe that the government does not belong in the credit markets. At the very most, this idea can only be viewed as a very expensive form of mortgage insurance.

Additionally, OMB has never provided any type of guidance to the agencies required to include this type of funding in their budgets as to how the program would operate. In the case of the VA, a huge sum of money will be deposited with the Treasury to finance foreclosures which will probably not be seen for several years. This proposal makes no fiscal sense.

Mr. Chairman, as you are aware, current legislation prohibits the selling of loans after 1989 without recourse, unless they can be sold at par. We foresee this measure restricting the flexibility of the Administrator to reduce the loan portfolio and effectively recapture funds. We would encourage legislation to allow the selling of loans without recourse with a reasonable, below par percentage limitation.

Mr. Chairman, at a time when the Home Loan Guaranty Program is showing claims in the amount of 50,000 per year, and foreclosures on property up to 25,000 per year, it hardly makes sense to arbitrarily cut the staff of the agency handling these claims by 45 FTEE simply to "save" money. It is very likely that no money will be saved and, in fact, the backlog of cases will grow even larger. It seems to us that more people, not fewer, should be put to work to counsel veterans in an attempt to rescue them from foreclosure. A loan counsellor who prevents only two loans threatened by foreclosure, saves the program enough money to pay for the position he or she occupies. Reductions in force make no sense in this instance.

The Department also proposes to change the regulations governing the acquisition of property on defaulted loans to provide for the inclusion of the cost of government borrowing in the calculations. As we understand the current process, the holder of the defaulted loan has the option to convey the property to the VA only if the "net value" of the property exceeds the total indebtedness minus the amount of the guarantee, or if a larger bid was made for the property as a minimum amount permitted under State law. Net value was defined as the fair market value minus the cost of acquiring and disposing of the property including taxes, maintenance and resale expenses. Adding the cost of government funds to this calculation only lowers the net value of the property, making the veteran liable for payment of additional monies should the VA not be able to sell the property at a price above what the veteran owes on the loan. This is not acceptable to The American Legion. In most cases when a veteran loses his home, he loses everything; it is extremely unlikely that the VA will ever be able to collect.

Mr. Chairman, we must remember that every loan issued by this program has a ripple effect on the community including local housing industries, real estate industries, builders, and lenders. The community itself benefits through an increase in the local tax base. This program has had a positive impact on the economy of this country and should be continued with improvements designed to restore the solvency of the program.

Mr. Chairman, The American Legion is proud to inform this Committee of a major accomplishment by our organization and the VA made possible by P.L. 100-198, the Veterans Home Loan Program Improvements and Property Rehabilitation Act of 1987. A provision of this law addresses the homeless program by allowing the VA to sell VA-acquired foreclosed properties for use as shelters, primarily for homeless veterans and their families, to any organizations named in or approved under section 3402 of title 38 as recognized by the Administrator, or any other government, public, or nonprofit organization or entity working on behalf of homeless individuals.

Legionnaires in Pittsburgh formed the Pennsylvania American Legion Housing for Homeless Veterans Corporation and purchased a four-unit home. The facility is operated by the Highland VA Medical Center and provides a home for veterans who have no place to live after discharge from the medical center. Legionnaires in the state raised $20,000 for the purchase of the repossessed property, agreed to appropriate an additional $5,000 for renovation, and donated furniture and building materials for completion of the project. The ten current residents at the home pay a small fee that is used for the maintenance of the facility.

We are very proud of this effort by the Pennsylvania American Legion and the Highland VA Medical Center and hope this will be the first of many more such ventures nationwide.

DEPARTMENT OF LABOR PROGRAM BUDGET

Turning to the Department of Labor, Mr. Chairman, The American Legion anticipates a marked improvement in the veterans employment services due to the enactment of PL 100-323, the Veterans' Employment Training and Counseling Amendments of 1988. We were pleased to see the FY 1990 budget proposals for the Assistant Secretary for Veterans Employment and Training at $162.6 million, a $5.1 million increase. However, we question whether this will be adequate to finance the increased responsibilities levied by PL 100-323. The Disabled Veterans Outreach Program (DVOP) received a $2.2 million increase to $75.2 million, while the Local Veterans Employment representative (LVER) program received a $2.3 million increase to $69.3 million. The National Veterans Training Institute received no increase in the $2.6 million from last year. For Federal administration of the programs, only a $600,000 increase to $15.6 million and a staff increase of 12 FTEE to staff three additional regional offices is requested. The Legion feels that the managerial mandates of PL 100-323 will greatly improve the effectiveness of the veterans employment services, however, we feel additional resources will be needed to fully satisfy the mandates.

The American Legion is concerned about the precarious nature of "employment tools" used by DVOPs and LVERs: the Veterans Job Training Act (VJTA) and the Targeted Jobs Tax Credit (TJTC). Although PL 100-323 extended VJTA for two years, the FY 1989 and FY 1990 VA budgets failed to fund this program which was tailor-made for Vietnam Era and Korean War veterans. Since its inception, over 19,000 veterans have successfully completed training and are now employed in meaningful jobs. They are now tax payers; assets rather than liabilities to their communities.

Although TJTC does not fall under the jurisdiction of this Committee, it is another program used by DVOPs and LVERs to get veterans off welfare rolls and onto payrolls. The 100th Congress gave TJTC a one year extension. Vietnam Era veterans are only one of the groups specifically targeted by TJTC. Over 35,000 veterans have re-entered the workforce thanks to TJTC. We would ask this Committee to help us persuade the Ways and Means Committee to make TJTC a permanent "employment tool." TJTC provides a small tax incentive for employers to hire those citizens identified as economically disadvantaged.

Much has been said during the election campaign about the Job Training Partnership Act (JTPA) and its impact on helping Americans get good jobs. Each year, the amount of funds allocated to Title IV C for veterans has remained disproportionate. We would ask this Committee to help us persuade the Committee on Education and Labor to increase Title IV C dollars.

CONCLUSION

Mr. Chairman, in this statement we have set forth for you and the Members of the Committee, the earnest opinions and positions of The American Legion on a variety of subjects that are included in the Reagan Administration's budget proposal for FY 1990 which we consider to be of special importance to the nation's veterans. We have addressed those programs we believe to be of highest priority in an agency whose activities are all of high priority, because they are intended to meet the needs, first of those who were disabled in war service, and then the reasonable needs of all those who served honorably when called to do so by this nation.

The proposed Veterans Administration budget for FY 1990 reflects an increase over the funding for the current fiscal year. However, it also contains some serious shortfalls.

For some reason, unknown to us, little if any attention is being focused on the impact that constant staffing reductions in the Department of Veterans Benefits is having on the quality and timeliness of the delivery of benefits and services to veterans. Amid lawsuits, complaints by veterans and service organizations, figures reflecting a deterioration of timeliness and a myriad of other negative factors, the Office of Management and Budget continues to chip away at the employment level of DVB.

Likewise, it is necessary to state again this year that the FTEE reductions in the Department of Medicine and Surgery are going to result in the erosion of the quality of medical care that is being provided American veterans. The number of health care professionals in the system simply cannot continue to be reduced.

The funding shortfall in the Department of Medicine and Surgery is having a decremental effect on the delivery of health care services to eligible beneficiaries. The Department has undertaken a myriad of policy changes in order to meet the projected shortfall when in reality, the VA health care system is seriously underfunded. More veterans are currently being turned away from VA medical facilities than in any previous year. Without substantial permanent increases in medical care funding this situation will continue.

The American Legion appreciates this opportunity to present its views on the FY 1990 budget, and we trust that the Committee will examine and consider the problem areas we have identified. We have commented specifically on those areas in which we feel there are the most glaring problems, and we have responsibly addressed each of the legislative initiatives with respect to the concerns of The American Legion.

Mr. Chairman, that concludes our statement.

NCOA

Non Commissioned Officers Association of the United States of America

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STATEMENT OF

C. R. (CHUCK) JACKSON
EXECUTIVE VICE PRESIDENT

before the

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

DEPARTMENT OF VETERANS' AFFAIRS
BUDGET REQUEST FOR FY 1990

February 9, 1989

The Non Commissioned Officers Association of the USA sincerely appreciates the opportunity to comment on the budget submission for the Department of Veterans' Affairs for FY 1990. *As submitted, the proposal reflects real decreases in funding for* compensation, burial benefits, readjustment services, loan guaranty, medical and prosthetic research, construction programs and cemetery grants. The proposal also suggests the reduction of 3,803 full-time medical care personnel, 616 researchers, 550 veterans' benefits personnel and other personnel changes resulting in a net reduction of more than 5,000 full-time employees. The Administration touts the proposal as a record request for the support of veterans. NCOA disagrees and instead sees this budget as a chronicle of denial and decimation of veterans' programs and services through years of inadequate budgeting.

Medical Care

Notwithstanding a proposed increase in medical care spending of $199 million, medical employment would decline by more than 4,000 full-time employees. The budget projects that requests for medical services will decline in all areas except outpatient care. Against all reasonable indicators the budget forecasts a decline of 15,447 hospital admissions, nearly 6,300 fewer domiciliary admissions and almost 8,000 less nursing patients. The projections make no sense particularly in view of the homeless rate among veterans and the increasing age of the veteran population.

Concurrently, the Administration has requested authority to collect co-payments from certain veterans seeking medical care at VA facilities. Their proposal would require veterans with non-service connected disabilities to pay $5 or $10 for outpatient visits, $9 per day for inpatient treatment and $3 to $5 for prescription medication. Only six percent of veterans would be affected by the fees according to the VA but they would pay $86 million for medical services.

Additionally, medical services continue to suffer from a shortage of qualified health care personnel. The system is supported by a cadre of dedicated physicians, nurses and technicians. Yet continued reductions in staffing are demoralizing and are taking their toll. NCOA recently received a letter from one VA psychologist decrying the loss of 59 training slots. The VA has always been proud of the fact that more than half of all physicians practicing on this country received some portion of their training from the VA. But as this individual points out, "Whole programs with traditions of excellence have already been sacrificed." In his words, "Training is not as important as the provision of services - - it is, nonetheless, important as the main feeder of high quality professionals into the system, and as a means of keeping high quality professionals in the system by involving them as trainers of new professionals." These issues hit particularly hard in research fields.

Taken together, limits on spending, fees charged to veterans and treatment of health care professionals do not bespeak a reliable system to provide medical care to veterans. It defines a system of roadblocks to such services. Compounded over the years, it is not surprising to see a projected decline in care requests because that is exactly what has been contrived by misguided budget proposals. It is that same mentality that has deprived the VA of the $1.45 billion needed just to make necessary renovations and repairs to rapidly aging VA medical facilities. And, it is the same mentality which arbitrarily cuts in half a $950 million construction request which would have provided desperately needed nursing home construction and improvements at other facilities.

NCOA believes it is time to reverse the trend. Accordingly, the association is opposed to staffing reductions, and reductions in medical and prosthetic research. NCOA vehemently opposes the implementation of additional user fees for medical care and other plans to further erode the availability of medical care.

Instead, NCOA urges a budget increase sufficient to reverse the trend. At the same time NCOA encourages greater use of innovative resources such as sharing agreements with the Defense Department. Although NCOA makes no specific recommendation, it encourages the VA to examine the recent defense base closure proposal for sites at which domiciliaries, nursing, or even shared hospital facilities might be appropriate.

Finally, with regard to medical care, NCOA encourages the committee to budget an amount sufficient to recognize the VA as an authorized health care provider under Medicare. Under current law both the VA and Medicare are empowered to provide certain services to veterans at the social security co-payment amount. Unfortunately, a veteran who has made such a co-payment to either the VA or SSA must make an equal co-payment to a VA or non-VA institution for treatment received at such separate facility during the same quarter. The revenue loss of such a change would be insignificant.

Compensation, Pension and Survivor Benefits

NCOA is pleased to offer its support for the 3.6 percent cost-of-living adjustment proposed in the Administration's budget for compensation and survivor benefits. However, the association remains opposed to indexing increases in compensation and DIC benefits.

Currently the annual review of compensation and survivor benefits prompted by the need for legislation to adjust pay levels assures that the programs will also receive comprehensive review. Congressional willingness to undertake this annual review assures NCOA that disability compensation and survivor benefits will not be allowed to suffer in the absence of legislated automatic increases. Thus, NCOA believes the benefits of annual review outweigh the benefits of indexing.

This year NCOA is hopeful such annual review will lead to the adoption of Representative Mike Bilirakis' bill H.R. 303 providing for the concurrent receipt of nondisability military retired pay and veterans disability compensation. NCOA is also hopeful the committee will review the distribution of benefits in the DIC program with an eye toward compensating all surviving spouses equally. Both of these are issues of equity which should have been addressed years ago.

Insurance Programs

NCOA recommends that amounts of insurance available through SGLI and VGLI programs be reviewed and increased to more adequately meet the needs of veterans. It has been three years since the current maximum coverage amounts were established. These rates have already been overcome by inflation.

Additionally, NCOA is pleased to recommend that military retirees subject to recall be allowed to retain VGLI on the same renewable term basis and for the same reasons as members of National Guard and Reserve components. Military retirees are a valuable national security asset. Since VGLI benefits are fully premium supported this is an excellent opportunity to provide a no cost benefit to deployable retirees.

Education Programs

Unfortunately the budget does not address any necessary or badly needed improvements in education programs. While NCOA's proposals are not expensive, they have nevertheless been overlooked.

NCOA continues to believe the pay forfeitures required for participation in the Montgomery G.I. Bill should be eliminated. Such charges only serve to discriminate against those who might benefit most from participation in the program but who by circumstances are financially unable to participate.

The association is also hopeful the benefits of the MGIB will be extended to servicemembers who were forced to retire between July 1, 1985 and June 30, 1988. Through no fault of their own and despite a willingness to continue to serve many career servicemembers will lose their opportunity for post secondary education because they have been caught in a vacuum between the Vietnam era and Montgomery G.I. Bill. Last year Congress acknowledged that personnel policies and reductions in force often preclude eligibility for benefits. Hopefully this charitable attitude will be extended to those who were involved in the MGIB test.

Finally, NCOA requests budgeting consideration of allowing Veterans Educational Assistance Program (VEAP) participants an opportunity to convert to the MGIB. VEAP participants are those individuals who entered service between January 1, 1977 and June 30, 1985. Today these men and women constitute the professional noncommissioned and petty officer corps. Yet by circumstance and timing, they have been denied participation in a real G.I. Bill. NCOA believes these individuals should be allowed to participate in the MGIB on the basis of their continued service.

Burial Benefits

NCOA continues to believe the regional cemetery system should be augmented by a series of smaller cemeteries in major population centers. Unfortunately the budget proposal only includes funding for the expansion of existing cemeteries. As a result of this nearsighted policy only about 40 percent of all veterans will live within a 50-mile reasonable access radius to a national cemetery. Hopefully the budget will be modified to include advance planning and site acquisition funding for cemeteries in major veteran population centers.

As it was last year, NCOA remains opposed to the elimination of the $150.00 VA burial plot allowance. In addition to being the only benefit many veterans will receive, the proceeds often inure to the support of state veterans cemeteries and veterans sections of private cemeteries. Its termination would send a very bad signal to veterans.

Finally, NCOA proposes again to expand the distribution of burial flags to include members of the reserves. In recent years the reserve components of the armed forces have assumed an ever increasing and integrated role in providing for the national defense. Reserve components are no longer stepchildren of the regular force. NCOA believes expansion of the burial flag benefit is one manner of acknowledging this new role.

Housing

Certainly among the most disappointing portions of the budget request are the provisions regarding the veterans home loan guaranty program. The home loan program is one of the most important benefit programs in the Department of Veterans' Affairs not just because of its obvious impact on veterans but because of its positive and continuing impact on the economies of communities across the nation.

Included in this portion of the budget are four proposals the Reagan Administration has tried to push on Congress before. Negotiated rates are at the top of this list, followed by an increase in funding fees from 1 percent to 3.8 percent, a replay of credit reform and a plea for without recourse loan sales authority. NCOA opposes all the recommendations.

Allowing negotiated interest rates among veterans and lenders does not even belong in the budget. It has no financial impact except to the detriment of veterans. Few mortgage companies really negotiate mortgage rates. Moreover, few homebuyers (veterans or not) have the experience, ability or knowledge to negotiate loans. Furthermore, nothing in current law prevents a veteran from negotiating a rate lower than the maximum rate set by the VA. The VA rate is the only fixed mortgage interest rate in the country. Accordingly, it serves as a benchmark by which all other rates are competitively measured. Its repeal would hurt all homebuyers and could lead to unjust lender profits.

Credit reform and without recourse loan sales are equally distasteful ideas. The credit reform idea requires the VA to deposit with the Treasury Department the "subsidy value" of all loans it guarantees. Such transfers would amount to $833 million in 1990 according to the budget request. But this figure has no basis. The actual subsidy value on a VA loan is only about $100 unless there is a default. Then the subsidy value can vary up to plus or minus 50 percent of the value of the loan. And, all subsidies are colored now by the size of the VA's inventory of homes and the deficit in the Loan Guaranty Revolving Fund (LGRF). When the LGRF was profitable through the 1970's there would actually have been a negative subsidy value on veteran mortgages. Essentially, credit reform is a shell game of accountability which NCOA opposes.

Last year Congress prohibited the without recourse sale of loans from the VA portfolio. In testimony on behalf of the prohibition NCOA used the following example. In late 1987 the VA announced it had sold $219.3 million in loans for $220.5 million. The margin by measure was .54 percent above par. The monthly income from those loans averaged .79 percent. In other words the VA sold a monthly income of more than $1.5 million for a one time profit of $1.2 million. Granted, a portion of the monthly income is consumed in loan administration, but not enough to outweigh the profit. Moreover, this was a par value sale. Imagine the loss on a without recourse sale at 40% below par. NCOA sees absolutely no compelling reason to return to without recourse loan sales.

Finally, NCOA opposes the proposed increase in participation fees. Foremost, the fee bears absolutely no relationship to the cost of guaranteeing any loan. Second, the fee provides nothing on default. (The VA not only keeps the fee but automatically devalues all property acquired through default by an administrative measure of 10.83 percent which is assessed as debt to the veteran.) This list could easily grow to unmanageable proportions, but the bottom line is the fee is without purpose. There is no program supported by the fees and it buys the veteran nothing. It is simply a veterans helping veterans shift of appropriations which the association opposes.

The veterans loan guaranty program needs innovation if it is to survive. This once profitable showpiece has been robbed of its future by the sale of the portfolio which supported its revolving fund operation. NCOA reluctantly concedes it is probably too late and too expensive to rebuild a portfolio capable of fully supporting the program. However, the association believes there are some innovative financing methods available. Among the most promising are federally insured housing bonds. Equally promising is a mortgage and life insurance model open to new and existing loans. And, of course, a premium supported mortgage indemnity program should also be considered.

Altogether, NCOA believes a number of options should be considered before fees are raised to meet an annual appropriation requirement.

Conclusion

There are a number of things about the current budget NCOA believes are ill-considered. Most notable is the document continues a trend of transferring the cost of veterans benefits to veterans. Hopefully, we have reached the low point NCOA can not explain to its W.W. II veterans why they must pay for VA medical care if it is even available; we can no longer explain fees for home loans and education benefits or the absence of even the most basic burial benefits.

Last year NCOA was criticized by the carpet at the VA for suggesting the VA was divorcing itself from veterans it exists to serve. NCOA suggested it was becoming more of an agency of veterans helping veterans. NCOA sees nothing in the current budget to dissuade it from this point of view.

However, the agency has tremendous potential to rebound. And it has tremendous potential to benefit from sharing agreements with DoD, and other agencies in providing veterans services. Hopefully, Congress will adopt a VA budget this year which will set the department on a renewed course of support for veterans.

Finally, NCOA recommends that the VA and Congress take a good look at the military's base closing list as a resource for new domiciliary, nursing, hospital and cemetery assets. Many of these bases slated for closing would very suitably meet VA needs for very moderate costs.

Thank you.

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STATEMENT OF
VIETNAM VETERANS OF AMERICA

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before the

HOUSE COMMITTEE ON VETERANS AFFAIRS

on

FISCAL YEAR 1990 BUDGET
FOR THE VETERANS ADMINISTRATION

FEBRUARY 9, 1989

Mr. Chairman and members of the committee, the Vietnam Veterans of America, Inc. (VVA) appreciates this opportunity to present its views on the budget for the 1990 fiscal year. In this statement, we will discuss what we believe to be areas in need of attention by the committee as it prepares its recommendations for the Budget Committee. Rather than discussing the specific figures presented in either President Reagan's final budget submission or those contained in the Independent Budget prepared by the VFW, DAV, PVA and AMVETS, we will treat each of these documents as a statement of policy choices. At the conclusion of this statement we will provide a listing of initiatives suggested for legislative action. These initiatives, or some combination of them, in our view would reflect the most appropriate policy choices needed to guide the VA in fulfilling the most important components of its overall mission. Naturally, we recommend that this committee adopt a budget plan for the VA that incorporates these policy choices.

In this connection, the last of the former Administration's budgets represents just one more installment in what has become a consistent and ill considered effort to reduce spending across the board. This is evidenced in this budget submission's proposals to reduce VA expenditures in real terms in virtually every VA department. Under the circumstances, this particular budget's statement of policy choices subordinates the operational needs of any of the VA's benefit or health programs to a blind-sighted fiscal imperative holding that all that really matters is cost reduction.

If we are mistaken in reading this particular budget's underlying policy choices, it seems that the only other alternative conclusion that could be drawn is that this budget is a set of policy choices designed to undermine most of what the VA has to offer the veteran including health care, benefits availability, counseling, the home loan program and so on. This is unfortunate because a budget submission with a request for the same amount of resources but configured differently might lend itself to more serious attention. As is, however, this budget must be discarded as unrealistic and without credibility.

The organizations having prepared the Independent Budget make this same point throughout their 1990 fiscal year proposal. For example, it is stated that "the Administration's budget requests have lost their credibility", "... the Administration's budget proposals did not reflect a realistic assessment of the problems now facing veterans", "[q]uality of care is eroding as a result of this Administration's lack of understanding of the implications of underfunding this large and complex system year after year.", "[e]qually disturbing was the obvious presence of a generalized demoralization of VA personnel caused by OMB's arbitrary budget cuts." and "[m]ost glaring, perhaps, is the admitted denial of needed medical care to eligible veterans and the deteriorating quality of care accorded others." (emphasis added)

The Vietnam Veterans of America agrees with these sentiments completely. Unfortunate as it may be, there appears to be a broadening consensus among veterans as well as the general public that the quality of VA provided health care is substandard at so many VA facilities that it is scarcely possible to be confident any longer that even the most deserving,the service disabled veterans, are being cared for properly or in a timely manner.

With this in mind, the challenge facing this committee and those of us within the veteran's community who are concerned about how best to assure quality service to those with the greatest, most legitimate, claim on VA resources is how can veterans best be served with the limited resources available. Although the VVA has not signed on to the Independent Budget proposal, as some 12 other organizations have, we recognize the importance of it as a policy statement containing the sincere interest and integrity of the four organizations that participated in its development. We give this alternative budget proposal credibility because it addresses the critical issues of health care quality and resources.

After having said that, however, we take exception to the manner in which these issues are addressed. As a statement of policy choices the Independent Budget attempts to meet three challenges. The first of these is to accommodate "the increasing demand on VA programs that stems from the aging veteran population." The second challenge is "to reverse the progressive erosion of the resources necessary to provide veterans their earned benefits." This particular challenge is clarified as meaning that quality health care, access to that health care and proper support for the hospital affiliation program cannot be restored without "vastly improved funding to meet program requirements." The third challenge is to fulfill the "unmet need for VA services", due primarily to severe reductions in personnel in the Department of Veterans Benefits.

As laudable as meeting each of these challenges may be, current fiscal realities make it impossible for any VA budget proposal to be all things to all veterans. The Independent Budget itself acknowledges this in spite of the challenges it attempts to meet. Were it otherwise, the proposal would likely ask for more than the $32.1 billion requested.

The policy choices this budget makes in health care become clearer upon examination of some of the language detailed in the section outlining this budget's strategy. For example, it is stated that "[i]n light of the need for austerity, an important component of our strategy consists of configuring our initiatives to actions dealing with veterans' most urgent needs...". What is urgent, according to this budget, is revealed when it is suggested that "[a]ll such savings" -- from normal annual cost savings in compensation and pension -- "should be regarded as available to meet the growing need for health care services that arises as the veteran population continues to age."

From the VVA's perspective, the health problems besetting a growing population of aging veterans cannot be ignored. Yet, neither should the VA's budget reflect a health policy choice that addresses this issue alone at the expense of other arguably more important issues. The VA's health mission, first and foremost, is to take care of veterans whose disabilities are directly related to military service. As meritorious as the case is for VA services to aging veterans, few of this particular population of veterans' ailments, for which care or treatment is sought from the VA, maybe related to military service.

In our judgement, given the VA budget crisis, a more appropriate and prudent health care policy choice would require a refocus of the VA's resources toward care and treatment of disabled veterans on a priority basis. One way of accomplishing this would be to drop veterans aged 65 or over from the VA's category"A" status by imposing the means test on these veterans who are not service connected and who are not indigent.

Moreover, the demands on health resources in the VA are mounting. Given the resource shortfall of between $600 million and $1 billion in the current fiscal year alone, it seems unlikely that a supplemental of that size will be approved. Under the current circumstances, category "B" and "C" veterans assisted at the VA's health system represent just over 6 percent, a relatively small percentage. This means that in many parts of the country the service disabled are being forced to compete for care with non-service connected veterans who enjoy the puzzling luxury of being in category A. Many NON service connected enjoy high incomes.

With a growing consensus that the quality of care dispensed at the VA is poor and deteriorating, it also seems wise to look closely at an alternative health policy choice designed to assure health care quality that is at least deemed satisfactory by service disabled veterans. Such a policy would authorize the service disabled the deserved privilege of selecting a health care provider of choice. Importantly, such a policy would not require a service disabled veteran to use a private sector health facility. It would instead allow the veteran to decide for himself or herself which health care provider, the VA or a private facility, offers the best quality and greatest responsiveness to health needs. So as to anticipate criticism of this particular option, it must be noted that "mainstreaming" is not being suggested here. Nothing in this proposal is designed to dismantle the VA health care system. All that is suggested is that the most deserving of our veterans be spared the requirement that they be subject to substandard and untimely health care.

If implemented, we strongly believe VA health care quality would improve as the VA undertook to compete with the private sector for the veterans it treats. Coincidently, the principle of choice as a solution to poor quality is the very same principle advocated by President Bush as a spur to improved quality in secondary education.

As with the above health policy choices designed to accommodate the needs of service disabled veterans first, yet another would require the VA to allocate far greater resources for the purpose of treating veterans with psychological problems such as Post Traumatic Stress Disorder (PTSD). These problems are clearly service related and in the case of PTSD these problems are predominantly related to combat. It is hard to imagine a greater claim on VA resources than that made by veterans with combat-related disabilities.

According to the VA's own Research Triangle Institute study as well as that just completed by the American Legion and Columbia University, the incidence of PTSD among veterans is for more prevalent than previously estimated. If it can be agreed that treating service related disabilities is a primary mission of the VA, than it must be conceded that treating veterans with PTSD represents a more pressing claim on scarce VA health resources than the need to treat aging veterans whose ailments may be altogether unrelated to military service.

An additional policy choice that is implied by the Independent Budget holds that the centralized management configuration of VA health resources is as it should be. This choice is implied in the absence of specific recommendations on the subject of how health care quality can be improved with a management reconfiguration. The current organizational structure is taken for granted as being appropriate and without consequence for health care quality. The VVA takes exception to this particular choice and we suggest a dramatic decentralization strategy designed to improve quality by placing decision-making authority in the hands of those best situated to make health resource decisions and be held accountable, the individual hospital directors. Without such a strategy, the quality of health care provided by the VA will continue to be held hostage to the parochial interests of bureaucratic managers from the VA Central Office down through to the Medical Region Directors.

In a letter sent to the Chairman of this committee last year, we pointed out that the single most pressing problem or issue for the VA health care system is the questionable quality of health care at the medical center level. The inability to control, direct, and manage the medical center from the medical center itself is creating serious problems. Given all of the oversight by management above the medical center director level, the system has now become dangerous for both the veteran and VAMC management. The situation has lead to a kind of institutional paralysis where the director and key staff dare not engage in decision-making without checking with "CO", "Operations", "Regional", or "Resources". Clearly the best recognition of this devastating problem is the creation of the Management Efficiency Pilot Program (MEP), an experimental program which allegedly allows five VAMC's to operate relatively independent of the centralized hospital system. This experiment is intended in part to determine if VAMC's can do a better job without the heavy handed interference of Central Office. Unfortunately in this experiment while these VAMC's may have some control over their staff ceilings, they certainly have no control over the resource allocation system or methodology (RAM) which determines if these centers are losers or winners. If they are winners, as in the majority of these cases, they are not allowed to keep all of their gains. This brings about the very lack of management flexibility intended. In short, the MEP is a failure. It is our belief that most if not all of the quality of care issues come down to a matter of local management. Currently the VAMC's are unable to be held accountable or be given the authority and responsibility to properly manage.

It is our further belief that the VAMC's should be given direct responsibility for managing all of their appropriated health dollars. At present, too many appropriated resources are absorbed by the Regions and Districts for administrative staffing and bureaucratic gamesmenship. Without converting the VA health care system into a truly decentralized system, management decisions will continue to be made by those farthest from the patients and the continuing result will be poor care and unmet needs.

An adjunct indication of the Independent Budget's reliance on centralization is also reflected by the proposal to centrally control resources for Prosthetic and Sensory Aids programs (P&SA). While it is true that veterans needing replacement prosthetic devices must sometimes wait up to eight months -- two months in times gone by -- and while it is also true that the reason for this is reductions in resources at the medical center level, it must be understood that the problem is not caused by the medical centers. The real cause is the imposition of reductions from Central Office and Medical Region managers.

The Independent Budget advocates "the entire P&SA budget be fenced and controlled through centralized allocation" in order "to help correct the alarming shift of funds and deterioration of patient care." If any budget resources are to be fenced it would likely be more appropriate to fence them at the medical center level.

Perhaps more importantly this particular Independent Budget proposal indicates that its authors have yet to appreciate the adverse effects the large and strongly centralized VA health bureaucracy has had on health care. An appreciation for modern organizational management principles that bemoan centralized mega-bureaucracies such as the VA has apparently also been missed.

Yet another of the centralizing proposals that is made by the Independent Budget is designed to transfer all of the functions of the Department of Labor's Assistant Secretary for

Veterans Employment and Training over to the VA's Department of Veterans Benefits. This proposal is justified simply as "having made sense for a long time...".

It is difficult to imagine how veterans would benefit from this proposal since all veterans employment programs operate through a single conduit, the state employment security agencies around the nation. No change of location for the operations of the the Assistant Secretary of Labor for Veterans Employment will change that basic reliance. On the other hand, the Independent Budget is replete with references to historic cuts in the VA's Department of Veterans Benefits. Are the Independent Budget's authors prepared to risk the health -- such as it is -- of the veterans employment program management configuration by placing it in an already budgetarily devastated arena?

For years, veterans employment programs for veterans have been criticized. The management, the design of particular programs, the configuration of delivery systems and even the Assistant Secretary in charge of these programs have been called to account for why these programs have never quite lived up to expectations. However frustrating, this fact is unlikely to change just because the VA would serve as the new umbrella for veterans employment programs. A seemingly more serious proposal would offer a solution designed to correct the failure of the state employment security agencies to access more than 10 percent of the employer community around the country.

Legislative Proposals

1. Means testing non-service connected veterans who are age 65 and older, not indigent and who have alternative health care resources.

RATIONALE: The service connected veteran must receive care first if there are going to be limitations on available dollars.

2. The Veterans Administration should serve as the fiduciary intermediary for veterans health care. As such, the VA Central Office (VACO) should purchase health care for veterans from VA Medical Centers (VAMC). The VA's medical districts should be the guarantor that the health care product meets quality standards and that the price the VA is paying is reasonable.

RATIONALE: Central office management of the national health care system from the top is inefficient. The VA health care system needs to be completely decentralized so that the medical centers can be held directly accountable for the services they provide. Further, the VA believes it provides health care less expensively than the private sector. If this is so, part of the reason is because it does not have to compensate for the cost of third party carriers as in the private sector.

3. Establish governing boards of veterans for each medical center.

RATIONALE: Veterans, in spite of their national representatives, do not have input into the overall management, programing, budget, and policies in the operations of medical centers as they should.

At the same time, these medical centers are subject to the centralized direction of Central Office and regional managers who have complete control over veteran programing, often to the disadvantage of the veteran. Many, including the veteran service organizations and some elements of the VA, seem to have forgotten that the system is supposed to serve the veteran receiving services at the behest of the public who ultimately pays for those services. The veteran at the local level needs to be an ally of the medical center and needs to participate in a democratic process that allows him/her to have direct meaningful input into what happens at the medical center.

4. The entire mental health delivery system of the VA should be reviewed in terms of program needs, availability, resource requirements and dedication, clinical and administrative organization and program priorities in view of budget constraints and competition with non-psychiatric programs.

RATIONALE: It has been well documented over the years that the VA has not been successful in the provision of mental health care to those veterans it serves. Further, there are certain clinical confusions relative to mental health delivery that need to be addressed.

As an example, the VA treats alcoholism, drug addiction, and PTSD in many of its facilities as separate non-interactional clinical maladies. Treatment for each is provided under separate programs, separate budgets, separate staffs, separate ideological rationales and separate medical school affiliate interests. This approach is not only very costly but may not be in the best clinical interest of the veteran being treated in many instances. The veteran whose substance abuse problems are a component of his or her PTSD is a classic example. Under the circumstances, both the substance abuse and PTSD problems must be treated together.

5. The relationships between the VA and the teaching affiliations as well as between the VA and the private sector should be carefully examined for the purpose of determining how the veterans have been and can be affected both adversely and beneficially by change.

RATIONALE: Medical center directors have frequently noted the undue influence medical affiliations have had on their medical centers. The medical affiliations, by definition, have a set of priorities which relate to teaching, research and the interests of the medical school. It is well known that the first priority of the VA medical center is patient care. Unfortunately, and to the detriment of the veteran patient, these two sets of priorities often conflict. In the areas of treatment programs, medical appointments and the allocation of funds, the medical school exerts too much influence over the medical center directors. This influence is usually on the medical center directly, but also through the VA medical regions and at the Central Office level via the office of academic affairs.

Medical Center governing boards of veterans could be very helpful to the medical center and its director in achieving a counterbalance regarding the medical school affiliations.

6. Eliminate the medical regions.

RATIONALE: As indicated in testimony we provided last September, the objective is to facilitate direct interaction between the VAMC's as providers of health care and VACO as purchaser. This action would benefit the veteran by reducing unnecessary organizational layering which leads to reduced accountability. The provider/purchaser relationship can be monitored at the district level. Additionally, as noted in the September testimony, the VA Central Office uses the regions to shield itself from corporate responsibility and accountability. Finally, the regions themselves have become too politicized in the sense that they have become seven mini-Central Offices at the expense of the medical center director's ability manage resources.

7. Eliminate national and local VAMC bed and FTEE ceilings.

RATIONALE: Regarding the bed ceilings, the determination and allocation of costs and revenues respectively are no longer meaningful in terms of the total number of beds throughout the system. The ceilings only distort realities in individual medical centers and skew bed vacancy and occupation rates. The relevant resources and staff required to service these beds therefore also become distorted. If a national bed ceiling is being maintained for the purpose of national defense, then this issue should be addressed independently of local medical center budgets. The medical center budget, after all, should relate primarily to patient care issues at the local level.

Regarding the personnel ceilings, a similar distortion as that with bed ceilings is introduced regarding allocation and determination of resources. As an example, the budget for a given year may be funded to accommodate a national ceiling of 194,000 FTEE when in fact due to changes in the system the ceiling may be much more or less. Importantly, a national ceiling of FTEE gives no real indication of what personnel levels at individual VAMC's really are. The current system of maintaining national bed and national personnel ceilings simply invites abuse and manipulation at all levels without tangible benefit to the veteran.

8. Authorize service disabled veterans to obtain medical services from providers of choice at VA expense.

RATIONALE: Veterans who are disabled as a result of military service are the most deserving of VA resources. Unfortunately, the VA's attention to so many other competing demands on the health care system has detracted significantly from the service disabled veteran's ability to receive health care on a priority basis. Additionally, the quality of health care in many VA facilities has deteriorated. In order to provide the best possible and most timely care to the satisfaction of the disabled veteran, a provider of choice program is needed to assure that the most deserving of the nation's veterans are treated properly.

9. Authorize a comprehensive program for addressing the high incidence of PTSD among veterans, particularly combat veterans.

RATIONALE: The VA's own Research Triangle Institute study (RTI) and the American Legion/Columbia University study have demonstrated that PTSD in veterans is far more prevalent than previously expected. The RTI study found that 15.2 percent of all male Vietnam theater veterans currently have PTSD. This is estimated to be 479,000 veterans. Another 27.9 percent of hispanic male Vietnam theater veterans, 47,000, have PTSD. Of white male Vietnam theater veterans, 13.7 percent or 359,000 veterans have PTSD. Among black male Vietnam theater veterans, 20.6 percent or 72,000 have PTSD. Of those veteran with or having had PTSD, only 10 percent have ever been treated by the VA. This situation is clearly deserving of serious attention and resources and is justified by the VA's primary mission of caring for veterans with service related disabilities.

The VVA recommends a significant expansion of the Vet Center program and a requirement that the VA open an inpatient PTSD unit in each of the 172 medical facilities over the course of the next five years. To develop and attract enough qualified personnel to operate these inpatient units, it is recommended that a scholarship program be developed and implemented for purposes of exchanging educational assistance, for graduate programs in training relevant to PTSD treatment, for a VA service obligation by each program participant. Such a scholarship program would be modeled after the VA's nurse scholarship program. In addition to this a pilot research program should be established with at least three inpatient PTSD units. Research conducted in these pilot units would be directed toward ascertaining the most effective PTSD treatment modalities. As the VA's general expansion of inpatient PTSD units proceeds, the findings of the research pilot units could be applied. Additionally, expanded resources for contract readjustment counseling in areas lacking "Vet Centers" should be provided and protected from reduction or diversion to other programs by the VA's Central Office management. Moreover, outreach must be taken seriously in the program. Finally, and in connection with outreach, the VA should undertake to assist penal institutions in identifying and properly treating incarcerated veterans with PTSD.

TESTIMONY

COLONEL HERB ROSENBLEETH, U.S. ARMY (RET)

NATIONAL LEGISLATIVE DIRECTOR

JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

February 9, 1989

Chairman Montgomery and Members of the House Veterans' Affairs Committee, I am Colonel Herb Rosenbleeth, US Army (Ret), the National Legislative Director of the Jewish War Veterans of the United States of America, a congressionally chartered veterans' service organization. On behalf of our membership, I thank you for the opportunity to appear today to testify before this distinguished committee.

Since it's founding in 1896, the Jewish War Veterans of the USA, the oldest active veterans' organization in the United States, has stood for a strong national defense and for just recognition and compensation for veterans. JWV is a voice for America's security interests around the world and it has always been a supporter of human rights issues.

Mr. Chairman, JWV members are responsible citizens, who clearly understand the meaning of federal budgetary deficits and who realize this nation needs to find a solution to our fiscal problems. As an organization we have not in the past, nor will we in the future, ask the Congress for more than we believe is fair and in the best interest of our nation.

Even with this in mind, JWV finds both the present Fiscal Year 1989 the proposed Fiscal Year 1990 VA budgets severely inadequate. Of greatest concern to our organization is a shortfall of some $650,000 in the VA health care budget. These funding inadequacies result from shortsightedness and neglect on the part of VA program and agency administrators and Office of Management and Budget's (OMB's) insensitive policy of decreasing funding for VA programs. JWV strongly opposes the view of Jim Miller, the recent Director of OMB, and members of his staff for stating that veteran's programs are "low-priority services." JWV believes veteran's programs are high-priority services and are among the most important national priorities.

The proposed 1990 VA budget would cut nearly 9,000 VA health care employees, reduce medical facility construction, and deny medical care to thousands of eligible veterans. In addition to the erosion of medical care for veterans, the new proposed budget would cut the Department of Veterans Benefits (DVB), which is responsible for the adjudication of claims for compensation, pension and education benefits, as well as home loan guarantees and burial benefits. DVB is short $30 million form their current services level and stands to lose another 6% of its employees. Since 1979, more than one-third of the DVB workforce has been cut, which has resulted in a continuous deterioration in the quality and timeliness of service to veterans. JWV vehemently opposes these further cuts!

JWV also strongly opposes VA proposals to:

a) increase from 1% to 3.8% the origination fee charged to each veteran for a VA-guaranteed home loan;

b) repeal the recently-reinstated travel allowance eligibility provisions to allow only veterans in need of special transportation or those who lived over 100 miles from a VA medical facility to receive this benefit; and

c) reduce medical and prosthetic research by $12.9 million and cut the number of full-time medical and research employees by 8,957 - from 199,852 to 190,895.

This type of perverse planning marks a continuation of OMB's relentless pursuit to reduce veterans health care benefits without legislation. They continue to reduce both employees and resources, and, therefore, fewer and fewer veterans receive medical care. Then OMB bases its next year's projections on the the reduced workload. Over a period of years this results in denied access and services to thousands of veterans. These veterans remain eligible for care, but the care is not available because space, personnel and equipment are inadequate. The VA is terminating health care programs, taking hospital beds out of service and denying health care to certain veterans at almost every VAMC. JWV emphasizes that the portion of the total federal budget being used by veterans programs continues to decrease, from 5 percent in FY 1975, to 3.3 percent in FY 1982, and down to less than 2.5 percent in this fiscal year. JWV sees any further reductions as totally unacceptable.

JWV officially endorses the concept of the Independent Budget prepared by VFW, AMVETS, DAV and PVA. This budget seeks to assure that the VA will provide benefits and services in a cost-efficient, timely and coherent manner.

The Jewish War Veterans of the USA appreciates being able to appear before this committee on this extremely important legislative issues. We are grateful to Chairman Montgomery and to this committee for your efforts in support of America's veterans.

THE
RETIRED
OFFICERS
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STATEMENT OF

THE RETIRED OFFICERS ASSOCIATION

before the

HOUSE COMMITTEE ON VETERAN'S AFFAIRS

on the

"FY 1990 BUDGET"

Presented by

Commander John F. Wanamaker, USN, Retired
Deputy Director of Legislative Affairs
The Retired Officers Association (TROA)

February 9, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:
I AM COMMANDER JOHN WANAMAKER, USN RETIRED, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS FOR THE RETIRED OFFICERS ASSOCIATION (TROA) WHICH HAS ITS NATIONAL HEADQUARTERS AT 201 NORTH WASHINGTON STREET, ALEXANDRIA, VIRGINIA. OUR ASSOCIATION HAS A MEMBERSHIP OF MORE THAN 359,000 ACTIVE DUTY, RETIRED AND RESERVE OFFICERS OF THE SEVEN UNIFORMED SERVICES. INCLUDED IN OURMEMBERSHIP ARE APPROXIMATELY 50,000 AUXILIARY MEMBERS WHO ARE SURVIVORS OF FORMER MEMBERS.

COMPENSATION PROGRAMS

THE 1990 BUDGET REQUEST FOR THE NEWLY ESTABLISHED DEPARTMENT OF VETERAN AFFAIRS SEEKS $318.1 MILLION TO FUND THE ESTIMATED 3.6 PERCENT COST-OF-LIVING ADJUSTMENT TO THE DISABILITY COMPENSATION AND DEPENDENCY AND INDEMNITY COMPENSATION (DIC) PROGRAM. OUR ASSOCIATION STRONGLY SUPPORTS LEGISLATION THAT WILL MAINTAIN THE LEVEL OF BENEFITS LOST TO INFLATION THAT WOULD REPLACE THE LOST INCOME DUE TO INJURIES OR DEATH WHICH THESE PROGRAMS ARE DESIGNED TO PROVIDE. I WOULD CALL TO THE ATTENTION OF THE COMMITTEE THAT THE INFLATION RATE OF 3.6 PERCENT MAY VERY WELL BE EXCEEDED, IT SEEMS THAT ESTIMATE IS MORE CONSERVATIVE THAN THAT PROVIDED BY MOST OTHER PRIVATE ESTIMATES OR EVEN THE MOST RECENT ESTIMATE OF 4.9 PERCENT FROM THE CONGRESSIONAL BUDGET OFFICE.

OUR ASSOCIATION URGES THE COMMITTEES TO INCLUDE IN THEIR REQUEST TO THE BUDGET COMMITTEES SUFFICIENT FUNDING TO CORRECT THE INEQUITIES THAT EXIST WHEREBY MILITARY RETIREES WHO HAVE SERVED 20 OR MORE YEARS OF MILITARY SERVICE MUST FORFEIT AN EQUAL AMOUNT OF MILITARY RETIRED PAY IN ORDER TO RECEIVE VA DISABILITY COMPENSATION. IT IS IMPORTANT FOR THE COMMITTEE TO UNDERSTAND THAT WE ARE NOT SEEKING CONCURRENT PAYMENTS OF BENEFITS BASED ON THE SAME DISABILITY NO DO WE PROPOSE THAT CONCURRENT PAYMENTS BE MADE FOR THE SAME SERVICE. WE ARE ONLY ASKING THAT THE GOVERNMENT PAY AN INDIVIDUAL THE RETIRED PAY HE OR SHE HAS EARNED BASED ON YEARS OF SERVICE AND, SHOULD THAT INDIVIDUAL BECOME INJURED OR CONTRACT AN ILLNESS IN THE LINE OF DUTY THAT CAUSES HIM TO LOSE

FUTURE EARNING CAPACITY, THEN THE GOVERNMENT SHOULD ALSO COMPENSATE HIM FOR THAT LOSS LIKE ALL OTHER VETERANS. THE ACT OF MARCH 3, 1891 IS THE BASIS FOR THE CURRENT LAW (38USC3104(A)(1)) AND HAS REMAINED RELATIVELY UNCHANGED SINCE "ITS" CODIFICATION INTO TITLE 38 BY P.L. 85-857 (1958). IT'S IMPORTANT TO UNDERSCORE THAT WHEN THE 1891 STATUTE WAS ENACTED, RETIRED PAY WAS BASED ON AGE AND YEARS OF SERVICE AND FIXED AT 75 PERCENT OF ACTIVE DUTY BASIC PAY. IN CONTRAST, ONLY 21 PERCENT RETIRE TODAY HAVING THEIR PAY COMPUTED AT 75 PERCENT OF BASIC PAY. IT HAS BEEN RULED IN THE OPINION OF THE U.S. COURT OF CLAIMS THAT IT WAS THE CONGRESSIONAL INTENT IN ENACTING THE ACT OF MARCH 3, 1891 TO LIMIT THE AMOUNT OF COMPENSATION AN INDIVIDUAL COULD RECEIVE AS A RESULT OF MILITARY SERVICE. AT THE TIME, THAT LIMIT WAS 75 PERCENT OF BASIC PAY. OVER TIME, WITH CHANGES IN BOTH THE COMPENSATION AND MILITARY RETIREMENT SYSTEMS, MANY DISABLED VETERANS ARE RECEIVING CONSIDERABLY LESS THAN 75 PERCENT OF RETIREMENT PAY DUE TO THE REQUIREMENTS OF THE WAIVER PROVISIONS.

DURING TESTIMONY BEFORE THE HOUSE VETERANS AFFAIRS COMMITTEE DURING THE 100TH CONGRESS, DEFENSE DEPARTMENT WITNESSES INDICATED THAT THE AMOUNT WAIVED EACH YEAR BY RETIREES WHO RECEIVE VA DISABILITY COMPENSATION WAS $765 MILLION. THAT AMOUNT IS THE TOTAL AMOUNT WHICH WOULD FAR EXCEED THAT WHICH WOULD BE PAYABLE IF THE 75 PERCENT LIMITATION WERE IMPOSED AND FURTHER DISREGARDED THE AMOUNTS PAYABLE TO THOSE WHO DID NOT SERVE AT LEAST 20 YEARS TO MAKE THEM ELIGIBLE FOR RETIRED PAY BASED ON SERVICE. SINCE THIS ISSUE IS A JOINT ARMED SERVICES/VETERANS AFFAIRS COMMITTEE ISSUE, I URGE THIS COMMITTEE TO COORDINATE THEIR BUDGET COMMITTEE SUBMISSION WITH THE OTHER PANEL.

MR. CHAIRMAN, THE BUDGET PROPOSAL, ALTHOUGH CALLING FOR A 3.6 PERCENT COST-OF-LIVING ADJUSTMENT FOR VA COMPENSATION, WHEN THE WAIVER REQUIREMENTS (P.L. 85-857) IS EFFECTED ON THIS INCREASE, THE NET RESULT IS NO INCREASE (IN FACT A LOSS OF PURCHASING POWER) FOR THOSE DISABLED VETERANS WHO ARE MILITARY RETIREES, SINCE THAT BUDGET PROPOSAL ALSO CALLS FOR THE ELIMINATION OF THE COST-OF-LIVING INCREASE FOR FEDERAL RETIREES IN FY 1990.

A similar situation exists when increases are made in the Dependency and Indemnity Compensation (DIC) program, in those instances, where a servicemember provided Survivor Benefit Plan coverage for his widow, that widow's annuity is offset by the amount of the DIC payment resulting again in no net increase if the proposals in the Reagan budget are favorably considered by Congress. Some military retirees do not waive military retired pay to receive VA compensation and the budget request asks that cost-of-living adjustment be eliminated for military retirees resulting in a loss in purchasing power to thousands of disabled veterans and by veterans widows who may be covered by the military Survivor Benefit Plan. I know that these programs receive oversight in the Armed Services Committees, but since they apply to veterans too, I want to bring this to your attention.

Finally, almost every federally administered survivors program including Social Security, Civil Service Survivorship Plan and Military Survivors Benefit Plan provide continued receipt of those benefits should the widow remarry after age 55. We urge the members of this committee to look upon these widows receiving Dependency and Indemnity Compensation in a kinder and gentler fashion and authorize the continuation of those benefits in a similar fashion. This committee's request to the budget committee should reflect favorable consideration of this request.

HOME LOAN INITIATION TAX

Legislation is being proposed to increase the one percent home loan initiation fee to 3.8 percent effective on October 1, 1989. I know that in recent years the Congress has rejected a much less ambitious increase in the VA Home Loan initiation fee. Our association would ask not only that you again reject the increase, but allow the current 1% tax be repealed. During the next 5 years, should the Base Closure and Realignment proposal be approved, that action will effect 145 installations, including 86 for closure, 5 for partial closure and 54 others for realignment.

OVER THAT 5 YEAR PERIOD THE PLAN CALLS FOR THE MOVEMENT OF OVER 56,000 MILITARY PERSONNEL A HIGH PERCENTAGE WHO EITHER CURRENTLY HOLD VA MORTGAGES ON THEIR HOMES OR WILL NEED THE ASSISTANCE OF THE VA HOME LOAN PROGRAM TO REESTABLISH THEMSELVES WHEN MOVING TO NEW LOCATIONS. THIS DOES NOT TAKE INTO CONSIDERATION THE TREMENDOUS LOSSES MANY WILL INCUR DUE TO THE NECESSITY THAT MANY WILL BE FORCED TO SELL THEIR HOMES IN A DEPRESSED MARKET TIMEFRAME WHILE AT THE SAME TIME PURCHASE NEW HOMES IN AREAS WHERE THE INCREASE IN HOME PRICES WILL REFLECT THE INCREASE IN MILITARY POPULATION. TO INFLICT A TAX INCREASE ON THOSE SERVING THEIR NATION IS INCONCEIVABLE. I BELIEVE THE INCREASE IN TAX OF VETERANS WHO MAY BE CIVILIANS SUFFERING SIMILAR DISLOCATIONS AND WILL NEED THE ASSISTANCE OF THE VA HOME LOAN PROGRAM TO BE EQUALLY UNJUSTIFIED. THERE MUST BE A BETTER WAY TO RAISE TAXES!

PERSONNEL MILITARY MOVEMENTS DUE TO BASE CLOSURES:

	OUT	IN
AZ	1,722	939
CA	17,658	4,815
CO	4	549
HI		2,267
ID	1,102	2,961
IL	3,452	336
IN	30	630
KY	37	302
LA	338	
MA	1,917	1,156
MD	240	142
MI		33
MO		300
MS		144
NH	2,250	
NJ	3,200	1
NM	2	1,448
NV		12
NY	244	345
OR	3	
PA	474	32
SC		661
TX	730	2,445
UT	174	148
VA	630	776
WA	345	1,239
TOTAL:	34,552	21,681

MEDICAL CARE

MUCH HAS BEEN SAID BY VARIOUS GROUPS THAT THE VA MEDICAL PROGRAM HAS BEEN DRASTICALLY UNDERFUNDED. TO DETERMINE THE PROPER AMOUNT FOR THIS PURPOSE IS BEYOND THE CAPABILITIES OF OUR ASSOCIATION TO MAKE, HOWEVER, THERE ARE AREAS THAT WE READILY RECOGNIZE THAT REQUIRE CONGRESSIONAL ATTENTION.

WITH THE PASSAGE OF THE MEDICARE CATASTROPHIC COVERAGE ACT AND BECOMING EFFECTIVE ON JANUARY 1ST OF THIS YEAR. A SITUATION HAS BEEN CREATED WHEREBY VETERANS ARE BEING SUBJECTED TO COSTS FOR THEIR HEALTH CARE WHICH EXCEEDS THAT REQUIRED BY SOCIETY IN GENERAL. MANY VETERANS IN CATEGORY "C" AND WHO ARE OVER AGE 65, ELIGIBLE FOR MEDICARE, ARE SUBJECTED TO MULTIPLE DEDUCTIBLES FOR CARE IN VA HOSPITALS. IN THE MEDICARE PROGRAM THEY WOULD BE LIMITED TO A SINGLE DEDUCTIBLE. THERE IS NO CROSS TRANSFER OF CREDIT OF VA DEDUCTIBLES TOWARD MEDICARE OR VICE-VERSA. IN ORDER TO CORRECT THIS PROBLEM I RECOMMEND:

A) ELIMINATE THE MEANS TEST FOR CATEGORY "C" BENEFICIARIES OVER AGE 65, OR

B) EXCHANGE DEDUCTIBLE CREDITS BETWEEN VA AND MEDICARE TO LIMIT THE COMBINED COSTS TO THE MEDICARE LIMITATIONS, OR

C) MAKE MEDICARE SUBJECT TO REIMBURSEMENT TO THE VA FOR CARE PROVIDED MEDICARE ELIGIBLE BENEFICIARIES.

OUR ASSOCIATION WOULD RECOMMEND A COMBINATION OF B AND THE ABOVE OPTION C BECAUSE THE MAJORITY CONSIDER THAT MEDICARE ENJOYS A FREE RIDE FOR THOSE OF THEIR BENEFICIARIES WHO ARE TREATED BY THE VA AND I DON'T HAVE TO TELL MEMBERS OF THIS COMMITTEE THE VA MEDICAL SYSTEM NEEDS THE FUNDING.

NATIONAL DISASTER MEDICAL SYSTEM

MR. CHAIRMAN, THERE HAVE BEEN MANY REPORTS THAT WOULD LEAD ME TO BELIEVE THAT OUR NATIONAL DISASTER MEDICAL SYSTEM PLANS MAY BE IN SERIOUS TROUBLE. AMONG SUCH REPORTS:

- VA HOSPITAL BEDS UNUSED BECAUSE OF SHORTAGE IN STAFF
- HIGH COST OF MEDICAL CARE (REFLECTS SHORTAGE OF PROVIDERS)
- SENATE ARMED SERVICES COMMITTEE REPORT THAT NAVAL RESERVE MEDICAL CAPABILITY TO BE A "WARSTOPPER"
- MILITARY MEDICAL FACILITIES OPERATING AT PARTIAL CAPACITY DUE TO FUNDING AND STAFF SHORTAGES

YOU MAY ASK WHAT HAS THIS TO DO WITH OUR CONCERN FOR VA HEALTH CARE. LAST YEAR THE VETERANS ADMINISTRATION INDICATED THAT IT HAD BEEN RELIEVED IN ITS REQUIREMENT TO PROVIDE A CERTAIN LEVEL OF HOSPITAL BEDS TO MEET NEEDS OF THE NATIONAL DISASTER MEDICAL SYSTEM PLANS. THE QUESTION I HAVE IS: WHO IS GOING TO MAKE UP THE SHORTFALL WHEN THE MILITARY TODAY CAN BARELY MEET ITS REQUIREMENTS? ARE WE MEDICALLY PREPARED FOR WAR? IF THE VA IS AN INTERGAL PART OF THE OVERALL PLAN THEN I BELIEVE THIS SHOULD BE INVESTIGATED. IF WARTIME PLANS CALL FOR THE EVALUATION OF CASUALTIES TO VA AND CIVILIAN HOSPITALS NEAREST THE CASUALTIES' HOME, THEN I HAVE SERIOUS CONCERN WITH THE VALIDITY OF SUCH A PLAN. AS ANY BATTLEFIELD COMMANDER KNOWS, A PRIME SOURCE OF REPLACEMENTS COME FROM CASUALTIES WHO CAN BE RETURNED TO BATTLE. IF THOSE WITH RELATIVELY MINOR WOUNDS ARE SENT HOME TO MAMA, I DOUBT IF OUR NATION COULD SUSTAIN ANY BATTLE OF SIGNIFICANT ENDURANCE. I BELIEVE THIS COMMITTEE SHOULD INSURE THAT ANY NATIONAL DISASTER MEDICAL SYSTEM PLAN REQUIREMENTS OF THE VETERANS ADMINISTRATION BE REVIEWED. THE RECOMMENDATIONS MADE ABOVE IN OPTION "C" WOULD ENHANCE THE VA'S CAPABILITY AND CONTRIBUTION TOWARD OUR NATIONS EMERGENCY PREPARDNESS.

THE FY '90 BUDGET REQUEST HAS ASKED FOR $17 MILLION IN DEPARTMENT OF DEFENSE FUNDS FOR A DOD/VA COOPERATIVE PROGRAM. WITHOUT KNOWING EXACTLY HOW THOSE FUNDS ARE TO BE USED, I WANT TO TAKE THIS OPPORTUNITY TO COMMEND THE JOINT EFFORT BETWEEN THE AIR FORCE AND VA TO MEET THE MEDICAL NEEDS OF THEIR BENEFICIARIES IN THE ALBUQUERQUE, NEW MEXICO AREA. OUR ASSOCIATION SUPPORTS THIS TYPE OF EFFORT IN JOINT SHARING REFLECTED IN THE BUDGET REQUEST FOR CONSTRUCTION OF THE VA/AF HOSPITAL IN LAS VEGAS, NEVADA.

IT SEEMS STRANGE TO ME THAT A VETERAN AND HIS WIFE WHO MAY LIVE NEXT TO A VA HOSPITAL MUST TRAVEL MILES AWAY TO A MILITARY TREATMENT FACILITY FOR HIS WIFE, WHEN BOTH ARE ELIGIBLE FOR HEALTH CARE UNDER DIFFERENT FEDERAL PROGRAMS. THE FY '90 BUDGET REQUEST REFLECTS A CURLTAILMENT IN TRAVEL FUNDS FOR NEXT YEAR. SOME OF THESE TRAVEL FUNDS COULD BE SAVED IF MORE COORDINATION BY JOINT FACILITIES OR

REIMBURSEMENT POLICIES COULD BE ADOPTED. THESE POLICIES SHOULD ALSO AUTHORIZE INTERCHANGE OF PRESCRIPTIONS FOR DRUGS BETWEEN AGENCIES AND PHARMACIES. IT OFTEN SEEMS THAT THE POLICIES ARE WRITTEN TO PREVENT COOPERATION. A THOROUGH REVIEW OF INTERAGENCY (DOD, VA AND HHS) COOPERATION IN HEALTH CARE DELIVERY NEEDS TO BE UNDERTAKEN WITH THE OBJECTIVE TO MAKE ACCESS TO SUCH CARE EASIER FOR THE BENEFICIARIES. I'M SURE IN THE LONG TERM, THE RESULT WOULD BE A NET SAVINGS TO THE GOVERNMENT AND BETTER SERVE THE BENEFICIARIES.

USER FEES (TAXES)

OUR ASSOCIATION URGES THE COMMITTEE TO OUTRIGHT REJECT THE PROPOSED LEGISLATION TO IMPOSE A "USER TAX" FOR OUTPATIENT VISITS, OUTPATIENT PRESCRIPTIONS OR PER-DIEM PAYMENTS FOR INPATIENT TREATMENT AT VA MEDICAL FACILITIES. THESE PROPOSALS RUN COUNTER TO THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (P.L. 100-360) WHICH WOULD LIMIT THE COSTS FOR HEALTH CARE FOR THE ELDERLY. WITHOUT A METHOD TO CREDIT THE PAYMENTS TOWARD THOSE LIMITATIONS FOR VETERANS OVER AGE 65 THEN THE PROPOSAL SHOULD BE REJECTED OUTRIGHT.

INSURANCE PROGRAMS

A RECENT ASSOCIATED PRESS ARTICLE LISTED THE NUMBERS OF DEATHS OF ACTIVE DUTY PERSONNEL OVER THE LAST DECADE. THOSE ACTIVE DUTY DEATHS AVERAGED 2021 FOR THE THREE FISCAL YEARS 1986, 1987 AND 1988. ASSUMING THAT EVERYONE WAS COVERED BY THE MAXIMUM AMOUNT AUTHORIZED, THE DEATH CLAIMS WOULD AMOUNT TO $303,150,000. REVIEWING THE VA BUDGET DATA FOR THOSE THREE YEARS SHOW THAT THE VA PAID $475,137,000 TO THE INSURERS. THAT WOULD INDICATE THAT THE INSURER RECEIVED $171,987,000 MORE THAN ENOUGH TO PAY THE ACTIVE DUTY DEATH CLAIMS. SHOULD THE REMAINING $171,987,000 BE REQUIRED TO INSURE THE ADDITIONAL 27,000 + RESERVISTS WHO REMAIN COVERED UP TO THE TIME THEY BECOME ELIGIBLE TO RECEIVE RETIRED PAY, THEN THAT COVERAGE SHOULD BE THOROUGHLY REVIEWED. I'M NOT SUGGESTING THAT THE COVERAGE

BE TERMINATED, HOWEVER, THOSE SAME RESERVISTS ARE NOW PROVIDED AN OPTION TO PARTICIPATE IN THE RESERVE COMPONENT SURVIVORS BENEFIT PLAN. IT'S ALSO MORE LIKELY THESE RESERVISTS ARE COVERED BY THEIR CIVILIAN EMPLOYMENT. THE SGLI PROGRAM REQUIRES LITTLE OR NO RISK FROM THE INSURER SINCE THE GOVERNMENT ASSUMES THE RISK OF DEATH CLAIMS ASSOCIATED WITH WAR-TIME OR NATIONAL EMERGENCIES. I NEED NOT REMIND THE COMMITTEE THAT THE INSURER HAS LITTLE OR NO REQUIREMENT FOR ISSUANCE OF POLICIES, PREMIUM COLLECTION OR MARKETING NETWORK. THE SGLI PROVIDES LIMITED ($50,000) COVERAGE LESS THAN AVAILABLE TO THE LOWEST GS-1 FEDERAL CIVILIAN EMPLOYEE. THE COVERAGE IS TERMINATED AT AN AGE WHEN THE INSURED IS CONSIDERABLY OLDER REQUIRING A TRANSITION TO MUCH HIGHER PREMIUMS AND THE PROGRAM DOES NOT PROVIDE COVERAGE INTO RETIREMENT AS DOES THE CIVIL SERVICE PLAN. IN SHORT, I DO NOT BELIEVE THE PROGRAM MEETS THE NEEDS OF THE SERVICEMEMBER.

WE RECOMMEND THAT THE COMMITTEE ESTABLISH AN INSURANCE PROGRAM IN-HOUSE THAT MEETS THIS NEED. I BELIEVE THIS CAN BE DONE WITHIN THE CURRENT VA OFFICES ADMINISTERING THE OLDER PROGRAMS AS THEY GRADUALLY PHASE OUT. IF YOU WONDER WHY I'M EXPRESSING SUCH CONCERN, THE BUDGET REQUEST FOR FY '90 IS FOR $182,700,000, WHICH INDICATES AN INCREASE OF $17.5 MILLION MORE THAN THE PREVIOUS YEAR, WHEN IN 1988 THE DEATH RATE WAS THE LOWEST YEAR IN THE PREVIOUS DECADE. WHY?!

NSLI PROGRAM

THE PAID UP ADDITIONAL COVERAGE ISSUED UNDER THE NSLI PROGRAM IS BASED ON A 4.5% INTEREST FACTOR. THIS IS THE ONLY METHOD MANY OLDER VETERANS HAVE TO PROVIDE ADDITIONAL INSURANCE FOR THEIR SURVIVORS. I BELIEVE THAT THE RATE USED TO PROVIDE THE ADDITIONAL PAID UP COVERAGE SHOULD REFLECT THE REAL VALUE OF THE DIVIDEND LEFT IN THE RESERVE FUND. THE FUND CURRENTLY IS EARNING INTEREST AT A RATE OVER 10% AND THAT RATE SHOULD BE TAKEN INTO CONSIDERATION IN DETERMINING THE PAID UP ADDITIONAL COVERAGE.

G.I. BILL EDUCATIONAL BENEFITS

LAST YEAR THE SENATE PASSED LEGISLATION TO RESTORE EDUCATIONAL BENEFITS TO A SMALL NUMBER OF BENEFICIARIES WHO

WERE INADVERTLY EXCLUDED FROM CHAPTER 34 EDUCATIONAL BENEFITS BY LEGISLATION PASSED IN 1976 WHEN THE VIETNAM ERA G.I. BILL WAS TERMINATED. AT THE TIME, AN ATTEMPT WAS MADE TO PRESERVE THE EDUCATIONAL BENEFITS UNDER THE OLD LAW FOR ALL MEMBERS WHO HAD MADE A COMMITMENT UNDER THE OLD PROVISIONS. THIS INCLUDED ANY RECRUITS WHO WERE COMMITTED BUT WERE IN A DELAY ENTRANCE PROGRAM AND CERTAIN RESERVISTS. WHEN THE MEASURE WAS PRESENTED TO THE FULL HOUSE FOR CONSIDERATION IN 1976, THE DISTINGUISHED CONGRESSMAN FROM TEXAS, REPRESENTATIVE TIGER TEAGUE MADE THE STATEMENT TO THE EFFECT THAT THE RIGHTS OF ALL THOSE WHO HAD COMMITTED THEMSELVES TO SERVE WOULD BE PROTECTED BY THE OLD LAW. HE EVEN WENT ON TO SAY THAT IF THERE WERE ANY THAT WERE MISSED THEY WOULD BE TAKEN CARE OF LATER. IT SO HAPPENS THAT THERE WERE OTHERS THAT WERE OVERLOOKED. THOSE CADETS AND MIDSHIPMEN OF THE ACADEMY CLASSES OF 1977 AND 1978 MADE SUCH A COMMITMENT AND EVENTUALLY SERVED ON ACTIVE DUTY MEETING ALL THE SERVICE REQUIREMENTS OF THAT COMMITMENT.

I ASK THE COMMITTEE NOW TO HONOR THE PLEDGE PROVIDED BY THAT DISTINGUISHED MEMBER OF CONGRESS WHO SPENT YEARS OF HIS LIFE IN PROVIDING FOR THE RIGHTS AND BENEFITS OF SERVICEMEN. LAST YEAR SUCH LEGISLATION WAS ENACTED IN THE SENATE, BUT FOR SOME UNKNOWN REASON IN THE LATE HOURS OF THE 100TH CONGRESS THESE MEN WERE AGAIN OVERLOOKED.

BURIAL BENEFITS

IT RECENTLY CAME TO MY ATTENTION THAT UPON THE DEATH OF A MEDAL OF HONOR RECIPIENT ALL IMMEDIATE FAMILY MEMBERS WERE UNABLE TO ATTEND THE FUNERAL BECAUSE OF FINANCIAL DIFFICULTIES. A BILL NOW BEFORE YOUR COMMITTEE (H.R. 451) WOULD PROVIDE THESE EXPENSES SIMILAR TO THAT PROVIDED PRISONERS OF WAR BY P.L. 93-257. BECAUSE OF THE GALLANTRY AND SELFLESS DEVOTION TO DUTY BY THESE INDIVIDUALS, THE UNITED STATES OWES NO LESSER DEGREE OF RESPECT, HONOR, OR SOLICITUDE TO THE MEMORIES OF THOSE MEMBERS OR FORMER MEMBERS OF THE ARMED FORCES WHO WERE AWARDED THE MEDAL OF HONOR. NO WORDS BY THIS HUMBLE PERSON CAN ADEQUATELY EXPRESS THE JUSTIFICATION OF THIS PROPOSAL.

MR. CHAIRMAN, THIS CONCLUDES MY STATEMENT AND I WILL ATTEMPT TO ANSWER ANY QUESTIONS THE MEMBER MAY HAVE. THANK YOU.

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Statement of
Claudette Morrissey, RNC
President
Nurses Organization of the Veterans Administration (NOVA)

Before the
U.S. House Committee for Veterans Affairs

February 9, 1989

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Mr. Chairman and Members of the Subcommittee, I am Claudette Morrissey a Registered nurse employed full-time as a Staff Nurse at the Veterans Administration Medical Center, Brooklyn New York. I am here today as President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the committee for the opportunity to appear before you. While I speak as the representative of NOVA, it is my goal to address the needs of the veteran patients cared for by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. NOVA is most concerned about the adverse effect on veteran health care of the proposed 1990 VA Medical Budget and the failure of the request for a supplemental appropriations for our present fiscal year.

The Administration's proposed budget, coming on top of the shortfall and the shortages we are presently experiencing seems like a cruel joke at the expense of veteran patients and the dedicated professionals who care for them. The hearts and consciences of VA nurses are touched daily as nurses strive to provide quality care on a timely basis to the veteran patient who seeks and deserves that care. We cannot believe that reductions of 8,957 total FTEE are being considered with full knowledge of the current desperate patient care situation.

Patient Care

From the perspective of the health professionals working on the front lines the budget cuts and shortfalls and workload adjustments of the past are having a very immediate human impact. The decreases in FTEE and increases in productivity proposed, mean that Registered Nurses giving care in the field are exhorted "*to do more with less.*" With the historic low staff to patient ratios in the Veterans Administration Hospitals, nurses are already running at full speed. There are not sufficient numbers of VA nurses to fulfill the VA mission of quality care. The ability to provide patient care is severely compromised when there are not enough nurses. Nurses know this in our minds and hearts and don't expect others to believe our instincts but we do expect them to believe our data. In VA hospitals we can document this daily by using a patient classification system. This system quantifies the minutes or hours of care patients with certain needs require. The number of hours of staff time available should be equal to the total number of hours of care needed by the patients. Nurses tell us the numbers just do not add up.

It is common that the number of hours of patient care far exceeds the number of staff hours available to provide the care. When this happens patients do not get the care they require. As one head nurse on a surgical unit reported, *"When I don't have enough nurses my post-operative patients run fevers because we don't have the staff to get them coughing, deep breathing and sitting up."*

Nurses experiencing this excessive workload are working so fast that we fear we will make a serious life-threatening mistake or that we will not be available to observe when a patient's condition changes for the worse. Many nurses entered nursing for humanitarian and altruistic reasons and are not afraid of hard work. What we do fear is that harm will come to a patient because we are unable to give them the nursing care they need.

Nurses throughout the country tell NOVA that the Nursing FTE have already been cut at their hospitals. Often when nursing positions are vacant because of recruitment difficulties, and the hospital budget requires that positions be cut, the empty nursing slots are sacrificed and the ceiling is reduced or frozen at a low number. In this case the vacancy rate looks low and the budget gets balanced. There is no real control over staffing when personnel budgets do not match personnel ceilings and neither of these reflect patient acuity and needs. NOVA's information confirms the VA survey of field facilities which reported budget reductions were cited for more than half the loss of registered nurses.

In the hospitals and clinics there are delays in scheduling patients for the medical follow-up and clinic appointments they need. For example, a psychiatric inpatient, with a concurrent medical problem needs an appointment in a medical or surgical specialty clinic it is not uncommon to be told *"we are not enrolling any new patients"* in this clinic. A patient caught in this situation is not receiving quality care. When a patient leaves the hospital on a new medication, he is often given a 30-day supply of medicine and a request from his treating doctor for an appointment in one month to review the effectiveness of treatment, development of side effects, need for change in dosage or medication, or a renewal of the prescription. Overcrowding in the outpatient clinics means the patient can't be scheduled for this appointment within the 30 day time and the renewal of medications becomes an urgent problem for the patient who then may wind up in the emergency room — certainly a more expensive and less satisfactory way of treating him.

When a reduction of inpatient care is mandated or required because of staff shortages and bed closures it means that veterans in need of hospitalization wait for admission. When needed medical or psychiatric treatment is delayed, the patient may become more acutely ill, the hospital stay may be prolonged or the rehabilitation less effective due to additional problems or complications arising during the delay.

Support Staff

Nursing is not the only area where there have been staff cuts or there are shortages. When there are shortages in other departments nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. Systems intended to increase efficiency and accuracy such as unit-dose medication are compromised when pharmacy is short staffed and pours 2 or 3 days of medication on the unit dose cart. The burden to adjust falls on the shoulders of nurses. When nurses are used as the all-purpose disposable employee, patients are deprived of nursing care and nurses get used up.

Supplies, Medications and Equipment

When NOVA asked VA nurses if there were "difficulties in securing adequate supplies for patient care?" the answer we received from 82% of those who replied was "yes" there are difficulties.

A summary of their most common responses includes shortages in supplies needed for patient care such as, Kleenex tissues, 2x2 and 4x4 sterile gauze pads, urinals, adult diapers, 5cc syringes, foley catheters, IV needles, bedside urine bags, Swan Ganz catheters, colostomy bags, rectal thermometers, water pitchers, mouthwash, toothpaste and a basic hospital staple — SOAP. Nurses in one hospital brought in souvenir hotel soaps and shampoos for the patients, and in another, brought and cut large bars of soap in small pieces for patients to use. A national shortage of latex gloves this past year was not unique to VA hospitals but it was an added stress as VA nurses attempted to institute universal infection control precautions.required as protection from AIDS.

IV solutions and common medications are also often ""Out of stock." The tight budget is frequently blamed when drugs are not available. "*Liquid haldol is too expensive*" we are told "*give it IM*" (Intra Muscular Injection) if the patient won't swallow the pill form. "Out of stock" items may seem like a simple inventory problem but there is an adverse affect on patients, nurses and physicians. For example, when a particular IV solution is not available nurses need to call or find the physician to re-write the doctors-orders for all the patients for whom that solution was ordered. This process absorbs the time of the physician and the nurse and deprives the veteran patient of their attention as well as the first choice in IV solution or medication.

In the name of budget constraints nurses report poor quality supplies are often substituted for those requested or recommended by nursing and medical staff. Nurses report this is particularly frustrating when this happens after the completion of a product comparison and evaluation period of 5 or 6 months, and nursing recommendations are ignored in favor of cost savings.

Nurses from coast to coast reported that the purchase of equipment has been severely curtailed. Many report that no new or replacement equipment has been bought in over a year and that equipment dollars have been used to pay salaries Basic equipment such as electric beds, infusion pumps, defibrillators, hydraulic lifts, wheel chairs, wheel chair cushions, and geriatric chairs are not available and the quality of patient care suffers.

Nurses are often very inventive in their efforts to minimize patient suffering. At one VA hospital in the south nurses were frustrated by the refusal of prosthetics to supply wheel .chair cushions for patients on the long term care unit. The nurses obtained a $25 donation, went to the local upholstery store and purchased a large foam mattress and with an electric knife borrowed from the mother of one of the nurses cut the foam to make wheel chair cushions for their patients.

When nurses in one hospital experience some of the shortages outlined above they are often convinced it is unique to their facility and caused by their: hospital director, chief nurse, chief of MAS, chief of supply, chief of personnel or chief of prosthetics. When NOVA hears similar reports throughout the country it seems clearer that nurses and departments everywhere are shifting and juggling and trying to survive in a system that is inadequately funded for the legislated mission.

Recruitment and Retention

The inadequate medical care budget has had an adverse impact on the ability of the VA to recruit adequate numbers of VA nurses. When NOVA polled nurses at medical centers across the country 83% of the respondents said there were not sufficient resources to recruit and retain nurses. The nursing shortage that NOVA and other organizations have discussed before this committee in the past has moved beyond the urban centers on on each coast and is evident now throughout the nation. Many VA nurses report that recruitment of nursing staff is severely hampered because VA hospitals are not competitive with community hospitals in salaries for the entry level nurse or for the highly qualified experienced nurse. They confirm that the VA is also not competitive with local hospitals in fringe benefits, tuition reimbursement, staffing levels, weekends off and shift rotation. VA's inform us they have little or no money available to advertise and attract applicants. For example, some VA hospitals have $500 per quarter for advertising or here in Washington, D.C. the VA hospital has a budget of $15,000 to attract applicants while NIH has a budget of $350,000 to recruit in the same marketplace.

The problems are not identical in every hospital. but it is not uncommon to take 90 to 120 days to fill vacant positions. The workload for the nurses who remain increases with each unfilled vacancy. The high turnover of nursing staff creates an even higher workload when there are frequent new and inexperienced staff who must be monitored and this higher workload perpetuates high turnover. This heavy workload affects recruitment because nurses frequently inquire about the nurse to patient ratio when they apply for work and decline employment when they hear the answer.

NOVA has stated in the past that overworked nurses are poor recruiters for the VA system. Retention of nurses already working needs to be our first concern. A cadre of satisfied, enthusiastic competent and caring nurses will be our best recruiters for the future.

It is difficult to know for certain why nurses decide to leave VA employment after many years of service. We contend that it is the cumulative effect of working short staffed, without the needed supplies and equipment and without competitive salaries and benefits that adds up and any one of these events can be the straw that breaks the camel's back. Overtime pay is such a straw to many nurses. They are asked to work overtime at a rate that is often less than their basic rate of pay. Nurses who work overtime should be paid overtime at the rate of pay they are earning.

The VA must no longer try to meet the budget targets by making unreasonable demands of nurses and breaking its covenant with sick and needy veterans. As the pressure has built to treat sicker patients in a more rapid time frame nurses have done their part. We have tried to prepare patients and families for earlier discharge. We have been a part of innovative non-institutional solutions such as Respite Programs, Adult Day Health Programs, Hospice and HBHC and utilization of community resources

As we stated earlier NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of all the difficulties described above. We are loyal and dedicated employees who pull together in difficult times, who like taking pride in what we do and dislike seeing the VA attacked and criticized from without. We are resentful when non-VA nursing colleagues indicate they think the VA is a second class place to work or assume that if you can't work elsewhere you can always work at the VA. We have glimpses from time to time of how great the VA health care system can be and take pride in the system's accomplishments. We have a worthy mission and need the resources to fulfill that mission.

Nova urges you to reject the Administrations proposal to cut the medical care budget.and urge you to restore the 8,957 FTEE we need to care for our veteran patients. NOVA urges this committee to request the necessary appropriations to provide competitive salaries for nurses by revising the basic pay scale for nurses. We also commend the Veteran Service Organizations who have prepared the **Independent Budget by Veterans for Veteran's Programs** and urge the committee to consider the intelligent and perceptive approach to the funding of VA medical care reflected in this document.

Thank you Mr. Chairman for giving VA nurses the opportunity to share with you and the members of the committee the unique perspective that nurses bring from the bedside of veteran patients to these proceedings.I am now prepared to answer your questions.

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NOVA SURVEY ON RECRUITMENT, RETENTION, SUPPLIES AND BUDGETING

NOVA was invited to recent testimony before the Senate Veterans Affairs Committee hearing scheduled for August 11, 1988. In an effort to provide the information requested by the committee, on July 19, 1988, letters were sent to all Chief Nurses, members of the NOVA Board of Directors and Chapter Presidents requesting answers to the three questions. The questions were: 1: Are there sufficient resources to recruit and retain qualified nurses? 2: Has the budget process caused difficulties in securing adequate supplies or equipment for patient care? 3: Are there signs of budget juggling that are impacting upon staffing and equipment for patient care? NOVA agreed to keep the comments confidential and agreed to keep the name of the facility confidential if this was requested.

RESULTS

NOVA received 49 responses from 45 different VA medical centers representing 29 states. The number of Chiefs of Nursing Service who responded was 26. There were 23 respondents from 20 chapters. Not all respondents answered all questions.

Question #1. Are there sufficient resources to recruit and retain qualified nurses?

	YES		NO	
CNS	6	23.1%	20	76.9%
Chapters	2	8.7%	21	91.3%
Total	8	16.4%	41	83.6%

Question #2. Has the budget process caused difficulties in securing supplies or equipment for patient care?

	YES		NO	
CNS	17	70.8%	8	29.2%
Chapters	20	100%	0	0%
Total	37	82.2%	8	17.8%

Question #3. Are there signs of budget juggling that are impacting upon staffing and equipment for patient care?

	YES		NO	
CNS	15	62.5%	9	37.5%
Chapters	16	100%	0	0%
Total	31	77.5%	9	22.5%

Many respondents included comments and explanations in their replies. They reported salaries are not comparable for the entry level nurse or the highly experienced nurse. The VA is also not competitive with local hospitals in fringe benefits, tuition reimbursement, staffing levels, weekends off and shift rotation. Most reported they had little or no money to advertise and attract applicants and that it often took 90-120 days to fill vacant positions.

The difficulties in having adequate supplies for patient care were demonstrated in the listing of shortages of basic supplies they had experienced most recently. These included: Kleenex tissues, 2x2 & 4x4 sterile gauze pads, urinals, adult diapers, 5cc syringes, foley catheters, IV needles, bedside urine bags, Swan Ganz catheters, colostomy bags, rectal thermometers, water pitchers, mouth wash, toothpaste and soap. IV solutions and common medications are also often "out of stock." Poor quality supplies are often substituted for those requested or recommended by nursing and medical staff. Many reported the purchase of equipment has been severely curtailed and that no new or replacement equipment has been bought in over a year. When there are staff cuts and shortages in other departments, nurses are often required to fill in the gaps.

CONCLUSIONS

The majority of all respondents answered that there were not sufficient resources to recruit and retain qualified nurses and that there were shortages in supplies and equipment that affected patient care. The Chiefs of Nursing expressed a slightly less grim view of the present situation but their responses were similar to those of the NOVA chapters that responded. The responses of all were incorporated into the statement of NOVA President Morrissey before the U.S. Senate Committee on Veterans Affairs in September 1988.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY
OF THE
AMERICAN NURSES' ASSOCIATION
ASSOCIATION OF OPERATING ROOM NURSES
AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES
ON THE
VETERANS' ADMINISTRATION
FY 90 BUDGET
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE

PRESENTED BY
LINDA S. SCHWARTZ, M.S.N., R.N.
MEMBER, ANA BOARD OF DIRECTORS
FEBRUARY 9, 1989

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Linda S. Schwartz, M.S.N., R.N., a retired Major in the United States Air Force. I am also a service connected disabled veteran, and have served as a member of the Connecticut Women Veterans' Task Force. I am a member of the Board of Directors of the American Nurses' Association (ANA), and appear today on behalf of the 188,000 members of the ANA and its 53 constituent state nurses associations to address the impact of the budget on veterans' health care. A significant number of our members are Veterans' Administration (VA) nurses. ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations. I am also pleased to appear today, on behalf of the approximately 40,000 registered professional operating room nurses who are members of the Association of Operating Room Nurses (AORN), and the 60,000 registered nurse members of the American Association of Critical-Care Nurses (AACN).

This hearing reflects the committee's continued commitment to the provision of quality health care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses; guaranteeing nurses the right of collective bargaining; encouraging nursing career development; providing educational opportunities; promoting clinical nursing research; and fostering the critical inclusion of nursing within the Veterans' Administration health care system. The committee has also stressed the inclusion of women veterans within the VA programs. Those policies have done much to ensure quality nursing care for all veterans.

The ANA has recently endorsed "The Need Is Now." An Independent Budget by Veterans for Veterans Programs, the independent budget recommendation submitted by four veterans groups. We are concerned that the President's proposed budget for the VA continues a downward trend in the necessary levels of monetary support for health care and research. This is occurring at the same time the VA is facing an influx of older and sicker patients. These veterans are more seriously ill. Their care is complicated by factors of age, the presence of chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge, and the rapid increase in the number of patients with acquired immune deficiency syndrome (AIDS).

The needs of patients in today's health care system require the care of a registered nurse (RN). The surging demand for nurses, a major factor in the national nursing shortage, provides evidence that efficient, effective utilization of qualified, experienced registered nurses is needed to preserve quality of care within the limits of cost containment. Unfortunately, this increased demand occurs during a nursing shortage crisis experienced throughout the public and private health care arena.

Years ago, VA hospitals were in the forefront with respect to nurses' salaries, benefits, and educational and professional development. However, as the private sector responded to changes in reimbursement, patient acuity, and health care manpower concerns, the VA has been unable to compete. The private sector can respond to market demands without any delay but the VA is subject to the appropriations process and budget restrictions. Nowhere is that more evident than in nursing recruitment and retention. We are concerned that where the VA once led the way in research and innovative clinical programs, budget reductions will impede the development of new care approaches.

It is especially important that the VA's advances in geriatric care and gerontological research and education not be curtailed. Additionally, as the numbers of aged veterans and those requiring long term care (patients with head injuries and HIV infection) increase, we must have adequate nursing homes and manpower to provide quality health care.

As a result of Fiscal Year (FY 89) budget restrictions, we have already seen veterans' access to health care adversely impacted. Many VA's have closed beds and units due to the inability to supply nurses, other VAs are examining their specific mission which may limit veteran access. Additionally, clinics in Chicago have been told to discharge stable patients and only service connected patients can be followed indefinitely. Community followup is questionable. Personally, I have to undergo a three month wait for an appointment regarding my service connected disability.

Budgetary reductions have also resulted in a reduction in nurse mix in several VA medical centers; in some, a 50 percent correction (staff reduction) has been ordered. Nurses from Illinois and California VA hospitals report freezes in employment of registered nurses, and licensed practical nurses (LPNs) and licensed vocational nurses (LVNs). The Illinois Nurses Association (INA) reports that one VA hospital has 20 nurses on waiting lists for hire because the hospital cannot foresee a ceiling for registered nurses because of budget uncertainties. In Region 6, several hospitals including Livermore and Reno reduced their RN ceiling in fiscal 1988 in anticipation of the FY 89 budget restrictions. How can we justify hiring freezes and reductions in nurse mix to veterans and VA nursing personnel when patients know there is an extreme nursing shortage within the system?

The freeze has also meant that in Illinois' Westside clinic RNs were rotated to emergency room with no orientation, many of whom do not have the requisite skills for emergency care duty. Similarly, medical-surgical RNs in the Martinsburg, West Virginia facility have to float to oncology units without sufficient orientation. In one California facility, the infection surveillance coordinator has been reduced to .5 full time employee equivalents (FTEE), and shares evening administrative nurse on-call duties. This is occurring while private sector infection control practitioners are reporting an increase in their workloads in response to the development, implementation, and compliance with occupational health standards for blood borne diseases such as hepatitis B and HIV infection.

Nurse managers have been instructed to increase non-RN staff to make up for RN reductions. However, VA medical centers report high LPN/LVN vacancies and turnovers and reductions in LPN/LVN ceilings. The VA cannot employ adequate numbers of LPNs/LVNs because they cannot compete with the private sector. This decrease in RN mix also means that the VA will have to utilize increasing numbers of lower skilled employees to provide health care to veterans. It may also mean that veterans may be deprived of essential life-preserving care and treatment. In North Chicago, INA reports that, if the chemotherapy nurse is on leave or ill, there is no replacement, and therefore no chemotherapy is provided.

Budget reductions have also apparently impacted the ability of some VAs to provide surgical services to veterans. Reportedly, one VA's surgical suites were in such poor condition that surgeons could not utilize them even after new advanced equipment was received. In addition, adequate appropriately trained staff were not available. The operating room nurses in the Martinsburg's VA are required to float to the medical-surgical units. The Lexington, Kentucky VA has had two nurse anesthetists vacancies for sometime. Both these situations may limit scheduling of surgeries.

The proposed budget will provide no funding for the revision of RN pay scales. As pointed out in "The Need is Now" sufficient funds ($400 million) must be appropriated to maintain the same level of staffing in FY 1990. Those funds must be provided in full and up front in order to eliminate the occurrence of serious shortfalls as they exist now. Past shortfalls have meant staff cutbacks and corresponding reductions in needed services for veterans.

Those existing shortfalls will result in a reduction of more than 100 RNs in the northeast region. Those numbers do not include nurse assistants, whose cuts could be equal to or more than the RN cuts. The mid-atlantic region has been instructed to reduce RN ceilings by 76 and LPN/nurse assistants by 25. Those facilities that have not reduced their staff will be required to do so in the future. Additionally, reductions in clerical, pharmacy and respiratory therapy will mean additional duties for RNs.

Decreases have occurred in funds for education programs, and no funds are available for the replacement or repair of equipment. Educational literature for substance abusers cannot be furnished. Low supply levels mean that veterans' care and treatment are delayed if outside purchasing cannot be expedited. Even basic medication such as lasix is not available The VA medical care program cannot continue to absorb the costs of pay raises and special pay. Congressionally mandated funds for personnel costs must be provided. We cannot continue to rob Peter to pay Paul when neither are adequately funded to meet veterans health care needs.

Lastly, and most importantly, we believe the VA's ability to provide quality care to veterans comparable to and not anything less than that offered in the private health care sector is critically compromised by the VA's inability to compete with the private sector's recruitment and retention programs for nurses. Although this committee and the agency have done much to facilitate VA competitiveness, much more needs to be done. We wholeheartedly advocate a change in the restrictive civil service pay schedules. Nursing staff and support salaries must be increased; at least 3000 beds are reportedly closed due to nursing shortages. The VAs in Louisville and Lexington, Kentucky and Cincinnati have hired nurse recruiters to combat the nursing shortage. The VA no longer leads the way with benefits such as salaries or retirement packages. Nor has the VA been able to supply the necessary computer assistance for nursing, as many hospitals in the private sector are doing.

We must reiterate that the FY 90 budget is insufficient to meet current services. However, if the reports we have heard are reflective of the impact of the FY 89 budget, those funds are sorely inadequate to assure quality health care provision to the nation's veterans; which means future shortfalls and further reductions in health care services to meet the money demands of an inadequate budget.

Thank you for the opportunity to address veterans' health care. We will continue to work with Congress and the VA to provide the nurses necessary to operate the VA health care system. We pledge nursing's support in implementing the programs and changes necessary to respond to the present and future health care needs of today's and tomorrow's veterans.

AMERICAN
ASSOCIATION
OF DENTAL
SCHOOLS

1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036

202/667-9433

STATEMENT OF THE AMERICAN ASSOCIATION
OF DENTAL SCHOOLS
SUBMITTED FOR THE RECORD TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

* * * * * * * * * * * *

ON

VETERANS ADMINISTRATION FY 1990
HEALTH CARE AND HEALTH RESEARCH BUDGET

The American Association of Dental Schools (AADS) represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. We are the only national organization concerned exclusively with the needs of dental education.

AADS is pleased to have the opportunity to submit this statement expressing our views on the Health Care and Health Research Budget for the Veterans Administration (VA) in fiscal year (FY) 1990. AADS hopes our statement will aid this committee in making its recommendations to the Budget Committee on budget levels for veterans benefits and services for FY 1990. Our comments will focus on areas of concern to the delivery of dental services and dental education activities in the VA. We support the overall health care and health research budget levels recommended by the "Friends of VA Medical Care and Health Research" coalition and the Independent Budget Proposal submitted by veterans' groups.

1. DENTISTRY IN THE VA: BACKGROUND

In order to provide a better framework for our budget recommendations, we will describe the various dental components in the VA in terms of: (a) dental personnel and patient care, (b) advanced dental education in the form of residency training, (c) geriatrics, (d) continuing education, and (e) dental research.

a. Delivery of dental services in the VA - Dentists, dental residents, and allied dental personnel (such as hygienists) are involved in providing needed dental care to veterans who are legally eligible for such care. Although inpatient and outpatient care can generally be provided for service-related dental conditions, veterans' eligibility for dental care is more restrictive than for medical care. One significant limitation is that medically adjunct dental care problems of inpatients can be treated, but this service cannot be provided to outpatients -- even where the attending physician determines that the treatment of oral health conditions is necessary for improving the overall medical condition. Another restriction is that home-based dental care cannot be provided, even if the dental problem is based on a service-related injury. AADS urges the committee to correct these serious obstacles to oral health for the nation's veterans. Specific proposals are raised later in this testimony, as they relate to the FY 1990 budget.

The VA is an excellent example of the total team approach to health care -- involving dentists, physicians, and health assisting workers. The VA dental staffing figures for fiscal year 1987 were: 925 dentists, 355 residents, 162 hygienists (12 fewer than the year before), 1023 dental assistants, 404 laboratory technicians, and 259 clerical workers. They handled 887,069 inpatient and 800,133 outpatient visits at VA dental clinics and related facilities. It is noteworthy that outpatient figures have been increasing relative to inpatient numbers in recent years. The resulting treatment rendered -- to 109,694 inpatients and 101,546 outpatients -- ranged from simple preventive interventions to complex restorative procedures.

In FY 1987 only 20,112 VA outpatients were treated on a fee basis by private dentists, compared to 101,546 at the VA. This has been a cost-saving trend in recent years, to absorb these outpatients more cheaply "in house" and save on fees sent to the private sector (where payments have been reduced from over $50 million a few years ago to only $10.3 million in FY 1987). The outpatient proposal we urge in this testimony would complement this cost-saving effort. The goal is to achieve better oral care for veterans at greater savings to the federal budget. It is not often that we can find a way to simultaneously improve health care services to veterans while lowering costs.

It is also noteworthy that over 2300 allied dental personnel (such as dental hygienists and lab technicians) from 120 affiliated institutions received some part of their training at the VA in FY 1987. AADS is concerned that personnel shortages may be developing in these disciplines; we are currently surveying that situation throughout the U.S. and will share our findings with the committee as soon as they are available.

VA dental services are provided to a patient population having oral health problems that are usually more severe than those of the general population. Often the oral condition is complicated by other medical problems. In fact, the VA patient population is similar to groups which have historically been underserved in our nation's health care system. According to the VA Medical Programs Report for FY 1990 (prepared by the VA Office of Budget and Finance), the VA hospital user -- compared to the overall veteran population -- is poorer and more likely to be single, disabled, older, and a minority group member. Given this special patient population with more complicated health problems, the VA needs to have well-trained primary care dentists with the sophistication to treat the various complex oral health needs of the veteran. Paramount is the need for general dentistry residents, who are trained in the care of elderly patients and other individuals requiring specialized care, such as the handicapped, medically compromised, and those infected with the AIDS virus.

b. Advanced Education via Hospital Residencies- The VA plays a vital role in dental education, as 72 of the 172 VA medical centers have affiliations with the 58 U.S. dental schools. The key educational connection is residency training for dental school graduates. These program are funded through a combination of VA and dental school support. The VA supports 155 accreditated dental residency programs (87 independent, 68 integrated) of several types; a majority are in general practice, with others in oral surgery, prosthodontics, periodontics, endodontics, oral pathology, public health, and anesthesiology. Residencies may be based completely at the VA, or based at an educational institution with a rotation through the VA; for example, 3 dental students in a school program could utilize one VA residency position. A total of 355 dental resident positions were budgeted for direct VA funding for the fiscal year 1987-88.

In fiscal year 1987 it was estimated that the VA was fully or partially involved in the training of 900 dental residents, about 25 percent of the nation's total. The VA provides close to one-third of all the general practice residencies (GPR) in the country (64 one year GPR programs as of January 1988). Thus, the VA is a significant supplier of trained personnel in an area that is vital to serving unmet needs; general practice is an area of under-supply for dentistry, and there are many underserved communities in need of general practice dentists (see 51 Federal Register 816, January 8, 1986 for a list of Designated Dental Health Manpower Shortage Areas).

These vital residency positions are threatened by the Administration's FY 1990 budget proposal. Adoption of the proposal would result in the reduction of 25 dental residency positions, which would seriously jeopardize oral health care for the nation's veterans.

The VA also has direct connections with dental students and faculty. Over 800 dental students worked as clerks in VA clinics in FY 1987, to supplement the clinical aspect of their dental education. 464 VA dentists hold part-time faculty positions with the affiliated dental schools.

C. Geriatric Dentistry- This is a critically important VA initiative, because of the more complicated medical problems of the elderly and the growing elderly veteran population. Oral health is essential for adequate diet and overall well-being. Healthy teeth contribute to the patient's ability to speak clearly and communicate. Also, a poor appearance of and discomfort related to the mouth and teeth may damage the patient's self-image and interaction with others. Recent estimates project a that an increasing percentage of veterans will be 65 years of age or older:

Year	Vet. Pop. (in millions)	Vets 65+	%	% incr. since 80
1980	28.6	3.0	10.4	--
1990	27.1	7.2	26.6	156
2000	24.3	9.0	37.0	255
2010	20.7	8.1	39.1	276

(Source: VA Geriatric Dentistry Newsletter, Feb. 1988)

Many more individuals 65 and over are retaining their teeth. It is estimated that the number of teeth in the U.S. requiring dental attention will increase significantly, from the present level of 2.6 billion to 5 - 6 billion in 2010.

Thus, continuing and expanding oral health care for the aging veteran can save high costs of rehabilitation in coming years.

In response to this trend, Congress established the Geriatrics and Gerontology Advisory Committee (GGAC) in 1980; this multi-disciplinary group of 12 health professionals and gerontologists advises Congress and the VA on methods to address the geriatric veteran issue. Three major VA geriatric initiatives since the GGAC's creation have been Geriatric Research, Education, and Clinical Centers, the Geriatric Fellowship Program, and a Center on Oral Health and Aging, all described below.

(1) Geriatric Research, Education, and Clinical Centers (GRECCs) - There are currently 10 centers located in: Bedford and Brockton/ West Roxbury, Massachusetts; Durham, North Carolina; Gainsville, Florida; Little Rock, Arkansas; Minneapolis, Minnesota; Palo Alto, California; St. Louis, Missouri; Seattle and American Lake, Washington; Sepulveda, California; and West Los Angeles, California. GRECCs have strengthened research on aging by consolidating local research expertise and attracting top scientists from beyond the local area. In fiscal year 1986 GRECCs received $17.4 million for research, and two-thirds of this support came from non-VA sources such as other federal agencies, private foundations, and corporations. The centers have conducted 11,500 inpatient and 16,850 outpatient evaluations, produced over 670 books or articles, and sponsored over 7000 educational activities.

Dentists may participate in GRECCs, but their participation varies by location. Although each center has one or several specialized research areas, none has a specific oral health focus. AADS urges the creation of a GRECC with such an oral health emphasis (as recommended by the GGAC).

(2) Geriatric Fellowship Program - Since 1982 the VA has operated this two year fellowship program (for dentists with specialized post-graduate training) at 5 VA medical centers in Boston, Denver, Loma Linda (California), Sepulveda (California), and Milwaukee. Starting with a goal of graduating 5 dentists per year, the program has graduated 20 dentist-geriatricians to date — 16 of whom have been appointed to VA clinical or research positions. The VA hopes to add one additional VA medical center to this program by fiscal year 1990. The geriatric fellowship program is a direct effort to meet a serious need for advanced geriatric training to provide a leadership cadre of dentist-geriatricians, as identified in Personnel for Health Needs of the Elderly Through Year 2020 (Sept. 1987 Report to Congress published by the U.S. Dept. of Health and Human Services). One example of the program's effectiveness is that all 5 program graduates in fiscal year 1984 sought research funding for age-related projects.

(3) Centers on Oral Health and Aging - In July 1984 the VA began discussions with the National Institute on Aging (NIA) and the National Institute on Dental Research (NIDR) on planning an inter-agency geriatric education and research initiative. Various researchers, clinicians, and academicians offered their opinion on the most pressing geriatric research areas. This collaboration led to the development of the first Center on Oral Health and Aging, which will allow for joint research and education projects among the three agencies.

The first center selected was the University of Florida College of Dentistry in Gainesville, which will receive 5 years of funding. There will be close utilization of the GRECC at the Gainsville VA. The research projects will focus on understanding the effects of aging on oral health, and improving problems such as gum disease, tooth loss, and facial pain. For example, one area of study will be on the impact of medication on saliva production; many drugs taken by the elderly decrease saliva production, which leads to increased oral health problems. AADS believes that this new center should be an essential part of future geriatric dentistry efforts.

d. Continuing dental education- The VA operates two dental continuing education centers, that are located in Washington, D.C. (for VA facilities east of the Mississippi River) and Los Angeles (for VA facilities in the western United States). Instruction is provided via one to five day live courses, or through a variety of audiovisual and programmed educational materials that are distributed throughout the VA system. All VA health personnel are eligible to participate, and many programs are open to non-VA personnel.

The Washington, D.C. continuing education center, established in 1954, conducts over 40 activities a year. In 1987 instruction was provided to over 600 VA employees and over 300 persons not affiliated with the VA, on topics ranging from management training to infectious diseases and the medically compromised. The center has produced almost 40 continuing education films for distribution to the various VA facilities.

In fiscal year 1987 the Los Angeles center conducted 40 live courses for 1389 participants, offered at either the Los Angeles center or various VA facilities. The center has also developed self-study courses that have been completed by 744 individuals. In fiscal year 1988 a course on oral manifestation of HIV infection was developed. As with the Washington center, their materials cover a wide range of relevant dental care topics, including an annual update on trends in dentistry.

One example of the scope of continuing VA health education for all health professionals is in the area of geriatrics, where 288 educational activities were provided in fiscal year 1986 for 9300 VA staff and 3200 non-VA participants at all VA continuing education field units (this includes the D.C. and L.A. dental continuing education centers and 17 other types of continuing education centers).

e. Dental research- The VA operates dental research centers in Houston, Texas and Ann Arbor, Michigan. The Houston center was started in 1967, with a research focus on caries (dental decay) control and the salivary glands. The small core of researchers is currently working on caries medication and oral lubrication materials.

The Ann Arbor center was started in 1983, with a research focus on dental materials. The center receives roughly two-thirds of its support through NIDR funding, and one-third through the VA. They are currently working on two multi-center research projects, that involve patient studies at 7 to 8 VA medical centers. One project is focusing on nickel-based alloys, and the other on crown and bridge materials. Much of the data collection at each site involves dental observation of the material's effectiveness. Since this type of VA study provides large sample sizes, it is an excellent model for future VA cooperative research efforts with dental schools. The Ann Arbor center has produced over 50 research abstracts to date, and plans to expand research projects to additional VA medical centers. In order to facilitate better patient care, research advances at both the Houston and Ann Arbor centers are disseminated throughout the VA system.

Dental research is also conducted through the traditional method of investigator-initiated projects. In fiscal year 1987, 117 VA dental staff members were actively pursuing approved research projects. This represents approximately 6 percent of the over 2000 dental personnel in the VA system. The GGAC notes that more VA dental personnel could be involved in individual research projects, and in our budget recommendations we will discuss how this goal could be achieved.

2. OPPORTUNITY FOR FURTHER STUDY

AADS is seeking to gain further information on VA dental education and services. To achieve this purpose, on February 6, 1989 we distributed a survey to all VA Chiefs of Dental Service. We posed questions dealing with dental school affiliations and possible improvements, outpatient issues, education program development, and recruitment and retention concerns, among other matters. We believe the results will be useful in analyzing future policy initiatives to improve VA dental education and service.

We also support the Independent Budget Proposal's (IBP) call for a survey of the unmet health care needs of veterans, with a particular focus in the outpatient area.

3. IMPACT OF THE ADMINISTRATION'S PROPOSED VA HEALTH CARE AND HEALTH RESEARCH BUDGET FOR FY 1990

Quite simply, the Administration's proposed budget is not enough to meet the oral health care needs of veterans and maintain a satisfactory level of dental service and training opportunities.

The VA health care and health research budget is not the appropriate place to cut spending in order to reduce the federal deficit. It should be recognized that cutting VA health care is no savings to the federal deficit, but merely a cost shift. Eligible veterans (mostly needy and indigent) who are denied service will simply be forced to seek care from other federal and state health care resources. This could simply mean greater costs for Medicare and/or Medicaid.

Most significantly for dental education, the Administration's budget would mean the reduction of 25 dental residency positions. Since the VA is a strong supply source for dental residencies (particularly general practice), SUCH A REDUCTION WOULD AFFECT THE ENTIRE SUPPLY OF GENERAL PRACTICE DENTAL RESIDENCIES IN THE COUNTRY.

We must stress that our nation cannot afford to educate health professionals in any setting with inadequate equipment, facilities, or quality of care. Our nation cannot afford to let the VA continue to drift toward this situation. The increased spending we are recommending for FY 1990 is virtually insignificant in the overall deficit picture, but will provide tremendous long run benefits for VA health care and health research.

AADS does support one of the Administration's dental outpatient proposals, if it can be considered together with our outpatient proposal. Both are described below under new initiatives for outpatient dental care.

4. BUDGET RECOMMENDATIONS- HEALTH CARE

AADS supports a FY 1990 VA health care appropriation of $12.42 billion. $12.02 billion would be needed to maintain the current level of service (based on the FY 1989 appropriation of $10.54 billion), and we are requesting $400 million for the new initiatives detailed below. Since 1980, the VA patient workload has increased without any increase in real dollar spending. The FY 1989 appropriation is at least $600 million short of what is needed. These shortfalls threaten relationships with all academic health centers. Increased funding is needed to prevent a downward cycle of quality decline based on cumulative damage from past inadequate funding. The value of dental school affiliations and the VA dental residency programs should be maintained.

AADS appreciates and indorses the Independent Budget Proposal (IPB) goals of improving health professionals training and research in the VA. We share their concern with improving outpatient services, and also support their request for a FY 1989 supplemental appropriation.

The special initiatives requiring increased FY 1990 funding are described below:

(a) Geriatric Research, Education, and Clinical Centers (GRECCs) - AADS recommends an increased appropriation of $13.5 million to expand the number of centers to 15. PL 99-166 mandates a total of 25 centers, so this would only be a partial step toward meeting this requirement. A more moderate request is made at this time in recognition of budgetary constraints, although this should be a high priority item in formulating future year budgets. GRECCs are essential for the advancement of geriatric research and education in an integrated health care delivery system.

AADS also recommends that all applicants for GRECC grants should be required to show evidence of efforts to conduct cooperative education and research with area dental schools.

(b) Other Geriatrics Initiatives - AADS supports $1.4 million for an overall geriatric training enhancement, as recommended in the IBP and "Friends of VA" testimony. At this time it is crucial to increase the number of residencies in geriatrics. We suggest that an optional second year of training in geriatrics be added to the existing one year dental general practice residencies. Such a program would enhance the skills of dental general practitioners in treating the special health needs of elderly patients, and would be a step toward addressing the shortage of geriatric training for health professionals identified in the Personnel for Health Needs of the Elderly Through Year 2020 Report.

AADS also believes that some of this increased funding should be used for geriatric training of dental hygienists, as recommended in the 2020 Report. Dental hygienists play a major role in the care of the institutionalized elderly, and would benefit from programs allowing them to develop clinical and academic skills in geriatrics and the treatment of the medically compromised.

(c) Education and Training- The initiative here is not for increased funding, but to preserve the existing residency positions. We urge that funding be provided to maintain the current level of dental residency positions in the VA. The Administration and OMB should not be allowed to reduce the number of residency positions based on a budget that has not been approved by Congress. AADS understands that the VA has taken steps to reduce residency positions, in effect complying with the Administration's FY 1990 budget as if it were law. We urge Congress to consider appropriate action to prevent this. Otherwise, the nationwide supply of dental residency programs will be damaged.

AADS supports the IBP and "Friends of VA" proposal for $6 million to enhance continuing education programs for health professionals. Some of this funding should go to support continuing dental education programs.

(c) AIDS- There has been a tremendous increase in costs due to the AIDS epidemic. The cost of treating an AIDS patient at a VA facility varies from $18,000 to $32,000 per patient. Infection control requires "universal precaution methodology" for each and every dental patient appointment, markedly increasing the cost of providing dental care. A precise estimate of dental costs within the VA is not available (although this was a matter of inquiry in the AADS survey), since all medical and dental supply and equipment purchases in the VA are consolidated. However, AADS has estimated that the average cost of modifying a dental school clinic (a location with exclusively dental care costs) to comply with more stringent infection control procedures is $200,000 per school. Dental care is extremely important because the signs of HIV infection often first appear in oral regions, and dentists are often the first health professionals to detect the disease.

As an important step in this area, AADS recommends an additional $3 million for an AIDS initiative, as recommended by the IBP and the "Friends of VA". While some of this funding should be used for education and training, we suggest that some also be allocated for new dental fellowships in areas of research, infectious diseases, and administration in cooperative ventures with affiliated dental schools.

The AIDS epidemic also creates an important need for continuing education of VA dentists in the detection and treatment of AIDS. Such programs should also be open to dental residents and students working in the VA, given the VA's role as a teaching site.

(d) Outpatient proposal- We support $100 million to expand outpatient visits as recommended in the IBP and "Friends of VA" proposal, recognizing the increasing number of outpatients in recent years.

AADS supports the Administration's proposal to permit dental treatment to be performed on an outpatient basis to certain veterans scheduled to receive hospital treatment. This could save more than $500,000 over each of the next four years. The proposal is to amend 38 U.S.C § 612 (f) (1) (A) to permit the VA to provide limited outpatient dental treatment to veterans scheduled to have certain hospital treatment (such as implantation of hip and knee prostheses). An estimated 10,000 patients a year fall into this category. These patients would only receive dental treatment that is professionally determined to be essential for care. Currently, patients who need such limited dental treatment prior to certain types of surgery are admitted as inpatients. This results in longer periods of hospitalization and increased administrative cost for the VA.

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Adoption of this proposal would eliminate this costly inefficiency. AADS proposes a similar change in outpatient dental eligibility in an effort to save money. Current law (38 U.S.C. sec. 612 (b)) limits veterans' eligibility for dental outpatient services to certain limited categories of veterans. The problem with current limits is that a veteran with a non-service connected disability, who is otherwise eligible for medical care (whether in category A, B or C), cannot receive outpatient dental care even when the attending physician believes that treating the dental problem would improve the patient's overall health. Instead, these veterans are often admitted to VA hospitals, where dental care is provided, BUT at a greater cost than if the patient were to receive dental treatment as an outpatient. We would be pleased to work with the committee on a change in authorizing language that would address this problem. **Such a change was endorsed by the Geriatrics and Gerontology Advisory Commi in its December 1987 report, "Oral Health Concerns of the Aging Veteran".**

(e) Recruitment and Retention of Health Care Workers- New programs are needed to address the shortage of health professionals in the VA system. One area of particular concern for dental education is the supply of dental auxiliaries such as hygienists. Increased funding in this area should allow the VA to study potential health profession shortage areas in the VA, and use funds to retain such personnel by offering increased salaries, continuing education, and advanced training opportunities. Congressional concern about this matter is evidenced by the addition last year of Expanded Function Dental Auxiliaries to groups eligible for the VA Health Professional Scholarship Program.

AADS supports the proposal for health manpower training grants for allied health institutions, with pilot funding of $5 million. This should be a model for alleviating shortages in any discipline. We believe that the authorizing language of 38 U.S.C. § 5091 should be modified to allow this approach for any discipline and related health professions schools where there is a shortage in VA personnel; such broadening of the authorizing language would provide the VA with greater flexibility in responding to personnel shortages.

AADS also supports the IBP and "Friends" proposal of $8.4 million to aid those seeking Associate degrees in allied health, in exchange for a service committment. We urge that the committee make clear that allied dental personnel are eligible for this program.

(f) Home based health care (HBHC)- AADS supports the IBP and "Friends of VA" initiative to spend an additional $94 million on home based health care. However, we believe Congress should explore the possibility of lessening restrictions so that dental care can be offered in this setting. This could be another source of savings for the VA, as preventive therapies in this outpatient setting will be extremely cost-effective as compared to the cost of rehabilitation that would result from neglect of the oral cavity.

5. BUDGET RECOMMENDATIONS: HEALTH RESEARCH

AADS supports a total appropriation of $249.1 million for health research in the VA, an increase of 19 percent over the FY 1989 level. This increase is needed to offset the decline in research funding since 1985, which no doubt has had a recruitment and retention impact. Costs of doing research have increased during this time, and as a result the number of merit review awards has dropped dramatically. About half of the research proposals judged to merit VA support will go unfunded this year. Our recommendation would restore the research budget to the FY 1985 level, supporting 1840 research projects. Special initiatives would be for 6 AIDS research clusters and 100 new AIDS projects, resulting in an additional $4 million appropriation over the current services funding level.

AADS supports the concept of cooperative studies in which researchers at multiple sites, working under a single project investigator and protocol, gather data at an accelerated rate and/or higher volume. This furthers the validity of the research, especially when dealing with an unusual disease or treatment entities. This type of effort also draws into research projects health personnel who otherwise might not have the opportunity to participate in research, particularly if research were limited to only individual investigators working at a single site. Such projects also encourage the involvement of academic researchers at dental schools.

In order to increase the number of VA dental staff involved in individual research projects, AADS supports the career development program. This program is essential for increasing the ability of VA dentists to effectively compete for individual research awards, as it produces a better trained core of dentist-scientists in the VA. The GGAC noted in its report "Oral Health Concerns of the Aging Veteran" that in the past VA dentists — unlike physicians — had not been encouraged to perform research. Career development awards are a good method of reversing this process.

CONCLUSION

AADS believes that the budget recommendations discussed above would provide the necessary level of health care and research for the nation's veteran population, while utilizing resources of the VA (in cooperation with U.S. dental schools) to provide better training opportunities for the nation's health professionals.

AADS thanks the committee for considering these comments.

Sauk County WI ALLIED VETERANS COUNCIL

Baraboo Post 26
Sauk Prairie Post 167
North Freedom Post 172
LaValle Post 242
Spring Green Post 253
Reedsburg Post 350
Plain Post 398

Baraboo Chapter 8

Thurber-Greenwood Post 1916
Parshall-Cummings Post 2336
Loganville-Hillpoint Post 3434
Lachmund-Cramer Post 7694

South Central Chapter 221

Sauk County Voiture 652

P.O. Box 439
Baraboo, WI 53913

JAN 27 1989

January 23, 1989

Chairman Sonny Montgomery
House Veterans Affairs Committee
335 Cannon H.O.B.
Washington, D.C. 20515

Dear Chairman Montgomery:

Please present this as testimony at the budget hearings in February.

We are writing you regarding your news release dated January 9, 1989, "VA Budget Plan Draws Congressional Fire."

We are in full agreement with the article and sincerely support the committee's attempt to do something about the problem.

We, here in Sauk County, are closely associated with Veterans Administration Medical District #16. Our county Veterans Service Officer recently received the attached communication from Mr. R.E. Struble, Director. We feel that the cutting of medical benefits is directly related to the budget. Administrators are trying to do the same job with less money so they can receive a feather in their cap and get advanced in the VA Health Care System. It just doesn't work - the quality suffers along with quantity. It has been at least two years since anyone non-service connected from Sauk County was accepted into an Outpatient Clinic, even with the requirement to accept Category "A" patients.

We are hopeful that the trend of the past can be reversed and the Veterans Administration Health Care System can be fully funded to provide the care to the veterans who sacrificed for this great country.

Your consideration and help in the matter are greatly appreciated.

Sincerely.

Debra K. Phippen

Ms. Debra K. Phippen
President

1 Enclosure

cc: Senator Kohl. Senator Kasten
Representative Kastenmeier

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN MONTGOMERY

Question: 1. The budget proposed for Fiscal Year 1990 requests a decreased of $12.9 million in research for the VA. When the Agent Orange money and inflation are taken into account, the proposed decrease is really $21.9 million. In light of the extraordinary successes in VA research, why was this decrease suggested?

Answer: The President's request is based on policy decisions related to VA's demonstrated ability to compete for non-VA research funds.

Question: 2. How many fewer research projects than in Fiscal Year 1989 would be possible under the proposed budget?

Answer: In FY 1989 funding is available for approximately 2,450 ongoing research projects; 365 of these will be prematurely terminated in FY 1990. This is based on the assumption that no additional DoD reimbursable funds will be provided in 1990.

Question: 3(a). Would it be necessary to eliminate research projects in order to meet the proposed decrease?

Answer: Assuming the approval of the budget request and no additional DoD funding, 365 research programs will be prematurely terminated effective September 30, 1989.

Question: 3(b). If so, which projects will be eliminated? Will ongoing projects be prematurely terminated or will new starts be prevented?

Answer: See the responses to 3(a) above and 4 below.

Question: 4. What impact would the proposed reduction in research funds have on high priority research topics such as AIDS, PTSD, Heart Disease, Alcoholism and so on?

Answer: All existing projects and new proposals will compete for available funds. Projects will be ranked by merit review panels and projects with lower scores would not be funded. These scores, assigned by scientific peer reviewers to proposals they regard as meritorious, would have to meet the same level for all topic areas. The actual priority score level required for funding will be determined by the R&D budget and by the number of proposals received. Sufficient resources for AIDS research and other special emphasis areas are provided in 1990 to support the continuation of all ongoing projects.

Question: 5. What would be the impact of the proposed research reductions on recruitment and retention? What would be the impact of the proposed research reductions on the various VA affiliations with medical schools?

Answer: Medical Research Service will continue to show its willingness to support VA physicians' research. This includes providing a core of support for VA research as well as encouraging researchers to compete for extra-VA funds.

Question: 6. What was the original request of the Department of Medicine and Surgery for Research funds for Medical Research, for Rehabilitation Research and Development and for Health Services Research and Development? What was the request for the Agency for these three Research services?

Answer: We respect your desire for information on the budget process, but must insist on the maintenance of open communication within my department which requires confidentiality particularly on budget matters. If all written and oral communications made in the decision-making process are subject to review and public examination, there would be a chilling effect on the candor in the opinions provided me in reaching decisions on budget matters.

Question: 7. Based on the disparity between the actual and projected figures for FY 1988, what suggests that the FY 1990 figures will proved to be any more accurate?

Answer: The Committee Staff agreed to remove this question.

Question: 8. In FY 88, how much was saved, in both dollars and staff, through A-76 privatization savings?

Answer: During fiscal year 1988, the Veterans Administration completed four A-76 cost comparison studies which resulted in the savings shown below:

Study/Location	FTEE Savings	Dollar Savings (Annualized)
Fire Protection Leavenworth, KS 1/13/88	- 5*	$- 127,144*
VA Supply Depot Hines, IL 10/1/87	33	1,076,000
VA Supply Depot Somerville, NJ 11/30/87	11	176,000
VA Supply Depot Bell, CA 8/22/88	4	97,000
Total Savings:	43	$1,221,856

*Most Efficient Organization (MEO) study documented need for additional resources.

Question: 9. What is your record of success in meeting previous one percent productivity increase target levels?

Answer: The Bureau of Labor Statistics produces a productivity index developed from a combination of all measurable work data. This index shows an increase in measured output per employee year. The recent trend for Department of Veterans Affair's Veterans Health Services and Research Admininstration (VHS&RA) is illustrated as follows:

Fiscal Year	Annual Percentage Change
1982-1983	+3.0
1983-1984	-0.6
1984-1985	+1.7
1985-1986	+3.1
1986-1987	+3.4
1982-1987 average annual rate	+1.9

The Federal Productivity Measurement Project monitors annual productivity trends for the Veterans Benefits Administration (VBA), National Cemetery System (NCS) and the Board of Veterans Appeals (BVA) in the GOE Appropriation. The following are annual productivity changes for these activitites:

	82-83	83-84	84-85	85-86	86-87	5 Year Avg.
NCS	+2.6	- .4	+3.0	+6.6	+1.3	+2.7
BVA	+3.8	- .1	-3.5	-1.6	-1.7	-1.0

In VBA the one percent productivity increase goal in the 1990 President's Budget is based on the assumption the Department will be able to save one percent of its employment through reasonably expected productivity gains. These increases are in addition to savings separately included in the budget for modernization projects and other specific management initiatives. The Department's actual productivity record cannot be accurately assessed over the past several years because of distortions caused by severe shifts in Loan Guaranty workload related to changes in the economy, and other distortions caused by revisions in our end products in 1985. Generally, we believe our productivity will improve each year as the result of improvements in our procedures and better managment.

Question 10. This is the fifth year in a row that you have had to implement a one percent productivity increase. What steps or plans do you have to meet these reductions?

Answer VHS&RA: The one percent productivity has been prospectively reflected in the 1990 budget. It is anticipated that annual productivity increase will be realized through improved technology of health care delivery and support services.

VBA: Increased productivity is more clearly associated with specific initiatives, such as our modernization initiative, which will save 167 FTEE in 1990, enhanced training opportunities, and other improvements in management and administrative practices.

NCS: NCS is proud of having achieved, on average over a five year period, more than double the required productivity increase. We will make every effort to achieve similar improvement in fiscal year 1990 and are committed to achieving the required one percent increase as a minimum.

Investment in equipment and maintenance projects are key steps in improving our productivity. Use of graveliners is another important contributor to increased productivity, while at the same time beautifying the national cemeteries by preventing grave sinkage. In fiscal year 1989 to date, three new cemeteries have begun using graveliners, making a total of seven national cemeteries using them. Cost benefit studies will continue on the remaining cemeteries with at least 550 annual interments for the possible use of graveliners.

BVA: We do not expect the BVA to achieve a productivity increase during either FY 1989 or FY 1990. During the course of the several Congressional hearings held this past year regarding proposed judicial review, oversight of the VA adjudication system, and oversight of the BVA, the BVA's longstanding focus on productivity was subjected to intense scrutiny. Some BVA practices that were intended to stimulate greater Board-wide productivity and hold down BVA processing time were criticized as not being in the best interests of VA appellants or the VA appellate system. These matters were also issues in a lawsuit brought against the VA this past year by a veterans' service organization. In view of the consensus of opinion on this issue, the BVA issued a formal statement of policy during 1988 to further emphasize that all BVA decisions, without exception, would receive a full and thorough review by three BVA Board Members. This intensified focus on the quality and thoroughness of staff attorney and Board Member review combined with other BVA quality review programs does affect the BVA's productivity level. However, this tradeoff of emphasis between quality and productivity appears to address the widespread concerns that have been expressed regarding the VA's appellate program operations.

Question: 11. The President's Budget states that a current services budget for VA Medical Care is $10.8 billion. CBO, using the same assumptions, says its $500 million higher. In your opinion, is OMB accurately reflecting the definition of "current services" as used in the Congressional Budget Act of 1974 in its estimate? What is the explanation for this significant difference?

Answer: In the 1990 Reagan budget current services were based on OMB Bulletin No. 89-06, dated December 9, 1988, which provided specific guidance on the percentage increases to be used for personnel costs and all other costs based on the 1989 enacted amounts. VA Medical Care current services estimate reflects the OMB assumptions.

Question: 12. In your statement you note that employee levels are going down in the Department of Medicine and Surgery. Doesn't this mean that all of the "additional" employees needed to activate new facilities are being taken from some other activity in DM&S? Can you identify any DM&S activities that require fewer employees?

Answer: Annual changes in total employment levels are the net result of planned increases and decreases in various activities. The 1990 decrease in Medical Care employment is the net result of budgeted increases for initiatives such as facility activations and AIDS and PTSD treatment programs, offset by decreases for prospective productivity improvements and a redistribution of levels of care supportable in VA medical centers.

Question: 13. If the VA Medical Care system were to get no additional funds beyond those proposed in the budget, what changes would you make to improve the balance in the program? What would happen to the quantity of hospital, outpatient and other types of care?

Answer: One step already underway to improve the balance of the program is to redistribute resources in order to provide more equitable access to care for all veterans nationwide. To achieve this goal, the CMD decided to limit all Regions to the level of the lowest Region. Region 3 had the lowest percent of category B and C patients; (1.5 percent for inpatients and 8.3 percent for outpatients); so that has become the goal of the other Regions. The Regions have been given this percentage as an aggregate goal; not as a goal for each medical facility. Therefore, the percentages of Bs and Cs at various facilities within a Region may vary considerably for valid programmatic reasons.

At the resource level requested in the 1990 Reagan budget, the VA would continue to provide quality medical care to all veterans whose care VA is obligated by law to provide. The workload related to veterans whose care is on a resource-available basis is expected to decline.

Question: 14. In Section 1A of the "Program Resource Changes" in the proposed budget, you propose decreases in funding and staff based on the assumption that the level of outpatient activity will return to approximately 1988 levels. How do you arrive at this conclusion?

Answer: The lower outpatient levels in 1989 reflect the VA Medical Centers' reallocation of resources to live within the current appropriation level. In 1990, resources are adjusted to reflect a more permanent redistribution of the levels of care supportable in the VAMCs.

Question: 15. Recent trends seem to indicate an increased demand for services. How is this reflected in your assumptions?

Answer: Increased demand generated by those veterans who the VA is obligated to provide care (Catetory A veterans) is fully covered in the VA's 1990 budget request. Treatment of middle and higher income veterans will be on a resource available basis.

Question: 16. You state that management involvement and safety education should reduce the injury/illness rate in VA facilities and result in savings of $302,000 in FY 90. How do you arrive at this figure?

Answer: The figure is a reflection of the Office of Workers' Compensation Programs (OWCP) costs that could be avoided if injury/illness rates are reduced as a result of resources spent on management involvement and safety education. The figure is based upon: 1) a projected annual 3 percent reduction in the number of new OWCP injury/illness claims, and 2) the amount of carry over costs avoided by the reduction of claims from the previous year. The carry over costs are those costs which would have occurred if the claims had been carried over into a future year on the OWCP chargeback.

Question: 17. Under the CHAMPVA centralized payment center proposal, you projected a reduction of $223,000 due to an overall decrease in the recurring cost for FY 90 by $723,000. On what do you base your assumptions that the recurring cost will decrease in FY 90?

Answer: The start-up costs associated with the activation of the combined CHAMPVA Registration Center/CHAMPVA Payment Center will be completed in FY 89. Associated implementation costs relating to moving expenses, furniture, various equipment and fixtures, supplies, publication, postage, travel, etc. do not appear as recurring costs, to the same degree, in FY 90.

Question: 18. You have decided to set aside the Resource Allocation Methodology (RAM) due to the budget situation. How will that help the Department? What procedures or techniques will you use to distribute funds to the hospitals in place of the RAM?

Answer: The Department has not set aside the Resource Allocation Methodology (RAM) and will apply the current RAM to make a budget adjustment for VA Medical Centers in the allocation of the Fiscal Year (FY) 1990 budget. In recognition of the fact that technology in quantitative measurement systems for the allocation of resources is dynamic, the Department is currently engaged in the developmental efforts to improve these systems. The second generation of RAM is being developed to take into account quality of care and equity of access to care which are not addressed by the current RAM. The current RAM also contains workload generation incentives that in times of limited resources tends to unbalance funding priorities. An interim set of quantitative measures will be used in FY 1991 and FY 1992, in moving toward the second generation of RAM expected for use in FY 1993.

Question: 19. Please describe the role of Efficiency Reviews in OMB's Productivity Improvement Program. What are the range of costs and average cost of these Efficiency Reviews in VA's medical activities?

Answer: Executive Order 12637 requires each Executive agency annually to develop and submit a productivity plan to the Office of Management and Budget (OMB).

DM&S uses Efficiency Reviews to improve its productivity. Efficiency Reviews are internal management studies that review activities not scheduled to undergo A-76 cost comparison studies. While the study approach and techniques utilized are similar to an A-76 cost comparison study, an Efficiency Review does not result in a cost comparison with private industry or contracting out. The intent is solely to improve and enhance our in-house operation. The studies are evaluated by medical center management and improvements are implemented, but in no instance will an activity or any employee's position be contracted out as a result of these studies.

Initially, Efficiency Reviews were conducted only for such direct care activities as dietetics, housekeeping, office operations, medical information, and plant maintenance. The VA medical centers conducted these Efficiency Reviews primarily with their in-house staff. The average reported cost per study in FYs 1987 and 1988 was $6,503; the lowest cost was $143 and the highest cost was $56,441.

In FY 1987, individual medical centers contracted for 73 Efficiency Reviews at an average cost of $33,152; the cost of studies ranged from $5,258 to $189,297. Most of these Efficiency Reviews were for clinical activities (i.e., nursing, clinical laboratory, radiology, pharmacy, and biomedical engineering).

In FY 1988, the DM&S developed centralized contracts for Efficiency Reviews of nursing, clinical laboratory, radiology, pharmacy, and biomedical engineering. The average study cost was $23,329; the cost ranged from $12,672 to $29,624. FY 1989 costs were approximately the same; the average cost was $23,001.

Question: 20. DM&S has begun a very ambitious upgrade of DHCP equipment in order to support the eight new applications. How much additional staff will be required in the Information System Centers to handle this workload? What skills will be required of any additional staff?

Answer: We currently estimate that 61 FTEE ($2,853,000) of additional staff will be needed for technical support and advice to VAMC's concerning the new VAX computers and redistributed PDP11 computers.

Recruitment efforts for any additional staff will focus on personnel with specific backgrounds in telecommunications, networks and local area network configuration management.

Question: 21. What is the current status of DHCP Order Entry/Results Reporting?

Answer: DM&S made Order Entry/Results Reporting (OE/RR) its top development priority for DHCP in 1988. DM&S clinicians and, ultimately, patients stand to benefit from the increased emphasis being placed on ward and clinic level access to patient information.

The package has been developed by a consortium of Information Systems Centers (ISC), with the Region 5 ISC at Salt Lake City taking the lead. Alpha testing began at the Washington VAMC in May, and demonstrations to DM&S top management were conducted in June. Visits by congressional staff, OTA, GAO and others took place in summer and later in the year. The system currently supports standard ordering for inpatient pharmacy, laboratory, dietetics, nursing vital signs/measurement, radiology and MAS patient transfer and discharges. The Salt Lake City VAMC began Alpha testing OE/RR in early summer.

OE/RR software will be available for sites to beta test beginning in February, with the completion of internal verification. Large sites that are receiving replacement equipment will be in a position to begin using OE/RR following implementation of the first four Enhanced DHCP modules. The first version of OE/RR will be released in June 1989.

Question: 22. In December of 1987, the Hcuse and Senate Appropriations Conferees instructed the VA to leave the IHS systems in place at Big Springs, Philadelphia and Saginaw and to select two additional tertiary care hospitals for tracking changes in technology offered by commercial vendors. Has the Agency received the funding to carry out this mandate? Have the two additional test sites been selected?

Answer: To date the Agency has not received additional appropriations for this purpose.

The two tertiary care facilities selected to receive new IHS systems are Brooklyn, NY and Chicago (Lakeside). Big Spring VAMC has also been targeted to receive remote data processing support from VAMC Chicago Lakeside.

Question: 23. What will be the impact of not receiving additional funds for IHS? What is the current status of the RFPs for the IHS?

Answer: The Agency plans to reprogram FY 89 and FY 90 funds sufficient to cover the cost of the new IHS systems. Funding levels required are $1.4 million and $5.9 million in FY 89 and FY 90 respectively.

DM&S is proceeding with the site preparation for IHS systems at Brooklyn and Chicago, (Lakeside) in FY 89, thus laying the groundwork for accomplishing the Congressional mandate. The RFP was released to industry on March 7, 1989, and will be followed two weeks later by a vendor conference. The procurement timetable will be adjusted accordingly.

Question: 24. Following the passage of the Computer Security Act of 1987, a Congressionally mandated ADP Security Program has been imple- mented. What is being done in DM&S to implement this program?

Answer: In response to the Computer Security Act of 1987, sensitive computer systems have been identified, and the department has started to evaluate the DM&S computer environment to identify ADP security vulnerabilities.

DM&S developed an awareness and training program (as required by the Act) prior to the Act's passage into law, and distributed the first awareness film with training guides and other awareness materials to its field sites. DM&S is producing two additional films, one for managers and one on personnel security. In addition, DM&S has also revised and issued its ADP Security Policy and Guidelines within the past year. Many local sites have performed risk assessments and taken steps to improve physical, personnel, and systems security.

Question: 25. The FY 90 budget proposes an increase of $1.7 million and 40 staff for the Post-traumatic Stress Disorder program. Does this represent a real increase in funds to the VA? If not, where are these funds coming from? Does the $1.7 million reflect an accurate response to the VA's needs in this area?

Answer: The additional $1.7 million and 40 FTEE identified for PTSD programs represents a net increase to the Department of Medicine and Surgery's medical care budget for FY 1990. Findings of the National Vietnam Veterans Readjustment Study and our own workload figures suggest that an increase in funding for the treatment of PTSD is an appropriate and accurate response.

Question: 26. Are the Department of Medicine and Surgery and the Department of Veterans Benefits sharing computer data bases? Please give examples.

Answer: DVB and DM&S are not literally sharing data bases, but they are improving the automation of sharing data. These efforts include AMIE, automated transmission of compensation exam scheduling and results, and improving medical center access to veteran eligibility data on the target system.

Hospital Inquiry (HINQ) provides DM&S the ability to request eligibility information during the registration process:

- dates of military service
- branch of service
- character of discharge
- amount of VA compensation or pension
- service connected disabilities
- claim number, etc.

Communication links are established directly between a VAMC and regional data processing center (RDPC). Responses are in the form of electronic mail messages. Requests may be sent individually or in batches. Security keys are assigned to ensure veteran privacy and identify individuals making the request. HINQ allows medical centers to expeditiously act on patients' request for care. Typically the number of these transactions exceeds 30,000 per week.

The Automated Medical Information Exchange (AMIE) began as a local initiative within Medical District 9 in 1987. It has involved the joint efforts of both DM&S employees and DVB regional offices in the development of an automated system of exchanging veteran beneficiary information. DM&S is encouraging this development effort, which also has the endorsement of DVB, through national DHCP input and support with the goal of possible inclusion of the fully developed and tested software in a future national DHCP release. The project is a further example of inter-departmental efforts at sharing and exchange of information.

The initial pilot test of AMIE was approved 5/88 for District 9 (Atlanta) and now includes facilities in Districts 4 and 12. Development is to be in three phases:

Phase 1 - VA Form 7131: beneficiary information exchange.

Phase 2 - Automate VA Form 7132: admission/discharge information exchange including 21-day certificates.

Phase 3 - Automate compensation and pension exam requests and provide for electronic tracking of these.

The current test utilizes five VAMC databases which are linked by VADATS to two DVB regional offices.

District 9:	VAMCs	ROs
	Atlanta	Atlanta
	Augusta	Columbia, SC
	Columbia, SC	
	Dublin	
	Charleston	

Expansion of the AMIE pilot to District 12 (Miami) and VAMC Wilkes-Barre and the VARO Philadelphia in District 4 will occur over the next several months in order to further test the full functionality of the data exchange.

District 12:	VAMCs	ROs
	Miami	St. Petersburg
	Tampa	
	Bay Pines	
	Gainesville	
	Lake City	

Question: 27. How many FTEE and dollars will DM&S need to implement an ADP Security Program in 172 VA Medical Centers and meet the requirements defined in the Computer Security Act of 1987?

Answer: A minimum of 196 FTEE and $8.6 million is needed in order to place at least one ADP Security Officer in each of the 172 medical centers, one for each of the seven regions, one for each of the seven ISC's, and 12 at the department's National Center for ADP Security.

As an added note, in addition to the requirements of the Computer Security Act of 1987, the ADPSO acts as the facility Director's designee for development, implementation and monitoring of site specific ADP security procedures and for compliance with DM&S ADP security policy and guidelines. Medical centers operate 24 hours a day, seven days a week with patient, employee, trainee, volunteer, and visitor traffic throughout the facilities. It is an open environment. The VAMC campuses range from single high-rise buildings in urban settings to a variety of structures spread over hundreds of acres in rural areas. At each of these medical centers it is typical to have at least four different computing environments: DHCP, distributed processing, timesharing and research. The on-going ADP security activities to support the medical centers requires at least one full-time ADPSO.

Question: 28. You state that $10,000,000 will be needed for DHCP equipment. Does this figure represent a one-time outlay of funds or will a comparable figure be seen in the FY 91 budget projections?

Answer: The $10,000,000 in the 1990 budget represents a one-time outlay for equipment to support implementation of the mental health application. There will, however, be a request for $1,200,000 for maintenance of that equipment on an annual basis beginning in FY 1991. We have yet to formulate the FY 1991 initiatives, but any additional applications will be justified on the basis of their quantifiable benefits as well as their contributions to improved patient care.

Question: 29. You anticipated a $36,000,000 savings along with a decrease of 659 staff due to implementation of the DHCP mental health application. How did you arrive at these numbers?

Answer: The savings contained in the budget request are attributable not only to the mental health application but to all DHCP applications. These savings estimates result from Price Waterhouse cost/benefit studies of CORE and Enhanced DHCP applications.

Question: 30. You estimate a increase of nursing end point operating beds by 363 in FY 90. Is this enough to meet the increasing demand? If not, will new facilities be proposed in the future or will this conversion process be the policy of the VA?

Answer: The increase of 363 nursing home beds, through conversions, represent managerial opportunities to improve the economies and efficiencies of existing hospitals and reduce the cost of constructing new nursing home care units.

The last VA nursing home bed needs assessment was conducted in 1986. That assessment was completed using National Center for Health Statistics (NCHS) utilization rates from 1977. The VA will conduct another nursing home bed needs assessment during the FY 1989 planning cycle utilizing NCHS 1985 utilization rates. In addition, the assessment will consider the availability of State and community nursing home beds in determining the need for future VA owned and operated beds. Based on the assessment, the VA will prioritize facilities and determine the most efficient and economical means of increasing the number of nursing home beds (through conversion or new construction). If additional nursing home beds are justified, they will be considered during the preparation of the Fiscal Year 1991 budget.

Question: 31. How is Health Services Research and Development a part of your Policy apparatus in Central Office?

Answer: The Health Services Research and Development Service plays an advisory and "coordinating" role in addressing policy-relevant issues. When policy needs arise that require information based on research, the Service seeks to identify researchers working in the field who can assist in addressing the issues. When findings from HSR&D-supported studies address issues of potential interest to Central Office policy-makers, copies of abstracts and/or printed "Bulletins" are targeted for dissemination to identified staff and, when appropriate, special presentations are arranged.

Question: 32. Health Services Research and Development is supposed to be an arm for broad-scale analysis and study of the policies and problems of large-systems health care delivery. It was created long ago and is serving well the general institution of medicine. In recent years, there has been greater recognition of Health Services Research and Development and its role in improved delivery of medical service. How is Health Services Research helping you manage and solve some of your current problems?

Answer: The Health Services Research and Development program in the VA is designed explicitly to support the VA's health care mission (as is the entire program of VA research), based on the program's authorizing legislation. HSR&D funds are provided only for VA investigators (primarily with at least 5/8 time VA-appointments). Thus, most VA investigators serve also as clinicians or managers in health care settings and reflect both the perspective of the researcher and of the clinician. These investigators are unusual in their ability to recognize and address health care issues of particular importance to the veteran patient.

For example, an Addiction Severity Index developed initially by VA health services researcher/clinicians in Philadelphia has been published and adopted widely. VA investigators developed this index to assist in matching patients to appropriate treatment, having found that the best predictor of response to substance abuse treatment is the patient's pre-treatment psychiatric status. They suggest treating substance abuse patients with low psychiatric severity in an outpatient setting; those with more severe psychiatric problems in primary psychiatric treatment.

Several VA studies have focussed on quality-of-life improvements for elderly veteran patients. For example, methods of evaluating and implementing improvements to geriatric treatment program environments have been developed and disseminated widely by VA investigators.

The VA HSR&D Service also capitalizes on the unique capacity of the VA to address major issues through its large health care delivery system. For example, the HSR&D Service is conducting a four-site evaluation of the cost-effectiveness of adult day health care relative to nursing home care. Products from the pilot work for this study already are being disseminated, focussing on methodological advances in patient recruitment and selection, and measures of medical efficacy, utilization and cost. The Service is implementing an additional comparison this year, of VA adult day health care relative to such care funded by the VA but provided by the private sector.

The HSR&D Service also is working with other agencies to develop appropriate outcome measures to include in a Request for Proposals for a large-scale evaluation of Geriatric Evaluation Units. The Service plans to move toward conducting more such multi-site,outcome-oriented studies that are particularly appropriate to our large health care delivery system.

Question: 33. How many Health Services Research and Development Programs do you operate in the field? How are their research products included in VA's planning for the future in such publications as the Strategic Planning Projections and the Medical District Initiated Planning Program (MEDIPP)?

Answer: The HSR&D Service currently is supporting seventy-one investigator-initiated health services research projects. Nine HSR&D Field Programs encompassing 36 VA medical facilities also are being supported. These are a network of core VA staff assigned to selected field facilities, who collaborate with community institutions (e.g., schools of public health, research institutes) to accomplish the Service mission in their assigned local areas. The Service also conducts a special projects program, to coordinate service-directed projects, such as the adult day health care evaluation.

Results from studies conducted are targeted, as appropriate, for dissemination to those Central Office and Field managers who might use the results to improve patient care or planning activities. Managers incorporate such findings when appropriate into pertinent publications and into MEDIPP planning guidance.

Question: 34. Does the VA have a process of evaluating new and emerging information technology to improve health care delivery? Does the Health Services Research and Development Service help in this regard?

Answer: The VA's Department of Medicine and Surgery has developed a comprehensive framework for implementing, evaluating, and migrating information technology innovations to other VA medical centers. The evaluation framework is a three-pronged strategy that includes: 1)ongoing operation of the five IHS (Integrated Hospital Systems) as permanent laboratories for tracking changes in technology; 2) translation of selected innovations to test beds at one or more of five DHCP (Decentralized Hospital Computer Program) Centers of Innovation for evaluation in DHCP architecture; and, 3) deployment of proven technologies to VAMCs nationwide. Overall responsibility for this process is assigned to the Associate Deputy Chief Medical Director's Medical Information Resources Management Office (MIRMO). The responsibilities of many VA managers also incorporate evaluation of new and emerging information technology, as it is relevant to health care delivery in their assigned areas.

The Health Services Research and Development Service assists by supporting development and evaluation of information technology. For example, one HSR&D project has produced a prototype automated psychiatric records system that has been integrated with the facility's DHCP system. The investigator who has developed and evaluated this prototype system has observed improvements in clinical efficiency, care, and administration; his final report is being evaluated. MIRMO also has been working toward developing HSR&D proposals in medical informatics for potential support through the HSR&D peer review process.

CONGRESSMAN STUMP

Question: 1. Are there freezes in nurse hiring at DVA facilities and reductions in the nurse ratio in certain parts of the country? If so, please provide full details.

Answer: The mixture of staff at DVA medical facilities is largely determined by the facility director in concert with his/her clinical advisors. Personnel ceilings are established for each clinical service, such as Nursing Service, prior to the beginning of the fiscal year. Such ceilings are determined by clinical needs as well as the constraints of the budget. When a service attains its allotted ceiling, it can no longer hire new employees. This is not considered a freeze but a proper exercise of management control. There have been reductions in nurse ratios in some parts of the country, but these reductions have not been as a result of a freeze. Rather these reductions have been wrought by the inability of VA medical facilities to successfully compete with other health care institutions for scarce nurses. Although millions of dollars have been allocated to beef up salaries for shortage specialties, shortfalls in recruiting have occurred, particularly on the coasts. These shortfalls cause the reduced ratios you allude to.

Question: 2. It has been suggested that funds allocated for medical prosthetic supplies and services be used strictly for that purpose. Does DVA agree that these funds should not be reallocated?

Answer: Facilities identify the level of funding planned for prosthetic supplies and home dialysis in their operating plans. These levels are planned and adjusted by the facility based on their needs. To centrally control prosthetic expenditures through allocations or other means would take away local management's ability to respond appropriately to changing patient care demands and priorities. Prosthetics is critical to the delivery of health care and local management has the best understanding of how the elements should interface to provide the best possible care.

Question: 3. What is the DVA's current policy concerning the management of individual medical centers relative to the funds provided to each? What flexibility do the directors of these facilities have with funds allocated to them and to what extent can they move these monies between program areas depending on their particular needs?

Answer: Local management's ability to move funds among programs has increased substantially in recent years and particularly this year. While some accounts, such as State Home, training and readjustment counseling are still restricted, most accounts can now be interchanged by local management. This year savings recognized in the non-VA programs, fee medical, fee dental, community nursing home and contract hospital, remain at facilities to meet other needs instead of being withdrawn by Central Office. Since the 1989 appropriation would not support continuation of the 1988 workload levels, local management was provided with increased financial ability to respond to local patient care conditions and priorities in order to operate their facility while still maintaining control to meet legal and implied requirements.

Question: 4. Your testimony states that $3.8 million is included in the FY 1990 budget for the first year of a 2-year loan guaranty property management pilot program. What level of funding will be necessary for the second year of the program?

Answer The estimated 1991 cost of the property management pilot program is $5,221,000, which is a $1,458,000 increase over the 1990 level. This pilot will test the concept of utilizing private real estate firms to manage and dispose of acquired properties. Approximately 10 percent of the VA property inventory will participate in this test. The 1991 increase reflects a full 12 months of operation under the contract.

Question: 5. Do you think elimination of the $150 plot allowance benefit may have a bearing on a veteran's decision whether to be buried in a private or national cemetery, thereby increasing the workload and expenses of the National Cemetery System?

Answer: Elimination of the plot allowance could have a marginal impact on the National Cemetery System; however, the decision to be buried in a national cemetery is not based primarily on reducing burial costs. The decision is also based on the distance from a national cemetery, whether a spouse is buried in a national cemetery, and intangibles such as patriotism, pride in service to the country, recognition, and being buried with comrades.

Question: 6. If no future expansion is planned and the number of open national cemeteries will decrease significantly in the future, how do you intend to meet the need for grave space resulting from the increasingly elderly veteran population?

Answer: National Cemetery System policy is based upon siting national cemeteries in such a way as to serve the greatest number of veterans. The policy calls for an open national cemetery in each standard Federal region. The National Cemetery System also continues to work to meet veterans' needs by (1) encouraging expanded participation in the State Veterans' Cemetery Grants program, (2) phased development of presently undeveloped land in open national cemeteries, and (3) limited expansion of existing national cemeteries through acquisition of adjacent land.

Question: 7. What impact on workload and funding have you experienced since implementing the legislation mandating upright markers?

Answer: The General Operating Expenses cost and workload increases to date have been marginal, because the switch to upright markers is being phased in as gravesites in existing flat marker sections are exhausted. It is estimated that when fully phased in, the increased workload will equate to 8 FTEE and $160,000 annually in salary and benefits.

The requirement also increases costs to the Compensation and Pensions appropriation, as that appropriation funds the purchase and transportation of headstones as well as the headstone/marker allowance. It costs more to purchase and transport upright headstones than it does flat markers. The headstone/marker allowance is also based upon the previous year's average cost for headstones and markers. It is estimated that these additional costs will total $684 thousand for 1989 and rise to $2.0 million for 1994.

Question: 8. The Acting Administrator's statement to the committee on Tuesday of this week indicated that the $4.4 million requested for the State Veterans' Cemetery Grants program in FY 1990 will allow at least four states to participate in this program. Which four states? What is the magnitude of the projects planned for those states?

Answer: The referenced "four states" are not particular states or projects. The estimated four states represent the number of projects that could likely be funded from the requested amount based upon our experience with the grant program. All currently identified proposals can be funded with the $9 million appropriated for 1989. The National Cemetery System continues to encourage states to participate in the grant program.

Question: 9. We understand that physicians at the Columbia, South Carolina VAMC are being asked to do their own lab work because of staff cutbacks. Is this so, and if it is, do you believe it is consistent with the delivery of quality medical care or good staff morale when already over-worked physicians must spend part of the time doing work which should be done by technicians?

Answer: Physicians at Columbia VAMC are not being asked to do their own lab work because of staff cutbacks. Due to clinical management changes which were supported by the Dean's Committee and the Clinical Executive Board, physicians who desire routine blood tests at times other than phlebotomy rounds are required to draw those blood specimens for delivery to the laboratory. The rounds are provided twice daily during the week (Monday - Friday) and each morning on weekends. This exceeds the usual one draw per day provided at many other VAMCs. This management change has resulted in quicker test results and improved morale in Laboratory Service.

Question: 10. The VA has always been a leader in the area of research. Yet the Committee notes that the medical and prosthetic research appropriation will suffer a decrease of $12.9 million and 616 FTEE in Fiscal Year 1990. What areas of research have been scaled back, are adequate funds included for continuing research in the area of AIDS, and, finally, how do VA research funds compare to the National Institute of Health for FY 1990?

Answer: Assuming the President's budget request for Medical and Prosthetic Research and no additional DoD funding, obligations will be reduced by $32,182,000. The reduced obligations are mostly the result of the completion of DoD collaborative studies in 1989.

o Sufficient resources for AIDS research and other special emphasis areas were provided in 1990 to support the continuation of all ongoing projects. Current topics for this specific research effort include AIDS, alcoholism, spinal cord injury and tissue regeneration, and delayed stress disorders and other mental illness.

o We have chosen to obligate most of the FY 1989 DoD funds available for two years during the first year. In 1989, we will obligate $14.5 million of $17.0 million in DoD reimbursable funds. Assuming that no additional DoD funds will be available, we will terminate approximately 365 ongoing research projects on September 30, 1989. The reduction in the number of research projects is largely the result of reduced reimbursables from DoD in FY 1990.

o In addition to competing for VA research funds, physicians are encouraged to continue to compete for National Institute of Health grants and other federal and non-federal grants. In FY 1989, VA estimates that VA researchers will receive $100 million from federal granting agencies such as NIH. Since FY 1986, VA researchers have acquired over $240 million in grants from other federal agencies.

o The funding to NIH for FY 1989 is estimated at $7,147,247,000 and $6,776,727,000 for FY 1990. The FY 1989 total includes funds for an HIV program designated within the General and Special Funds of the Office of Assistant Secretary for Health. The FY 1990 total does not include funds for the HIV program. The VA budget for Medical and Prosthetic Research is estimated to be $210,241,000 for FY 1989 and $197,310,000 for FY 1990.

Question: 11. The FY 1990 budget proposes a reduction of 7 FTEE from the Compensation, Pension and Education (adjudication) program. Our Committee's data on the program indicates that during FY 1988 approximately 27.5 percent of compensation cases were processed within 90 days, a level which is well below your minimum acceptable level of 35 percent, and a level of 50 percent, which appears to be more reasonable. Additionally, an analysis of timeliness statistics for the past seven fiscal years indicates a direct correlation between your timeliness and the severe decline in average employment in this area. Please provide your comments regarding the rationale for this decrease and your plans to reduce claims processing time.

Answer: As the FY 1990 budget request is essentially unchanged from the current FY 1989 estimate, a net decrease of 7 FTEE out of 3,600, FTEE cuts would not be a factor in the ability of regional offices to meet timeliness standards. Improvements in timeliness are anticipated in FY 1990 based on productivity improvements and management initiatives.

Question: 12. In the current environment of scarce resources and staffing, but of continuing and increasing workloads, how can you justify a decrease in FTEE of 5,019 for DM&S, particularly since the majority of the decrease is in the areas of direct patient care?

Answer: Total average employment in the Department of Veterans Affairs will decrease 5,019 in 1990, including a reduction of 3,883 in the Medical Care appropriation. The decrease in VA health care employment is the net result of many factors included in the 1990 Presidential Budget which include increases for facility activations and PTSD and AIDS treatment programs, offset by decreases for continued productivity improvements (e.g., DHCP and PAID redesign) and a redistribution of levels of care supportable in VA medical centers.

Question: 13. No funds are included in the FY 90 proposed budget for additional nursing homes. How do you propose to handle the increasingly elderly veteran population, particularly since plans to convert existing hospital beds to nursing home care use have not had expected results?

Answer: The FY 1990 budget does not include funds for additional (new) nursing home beds. However, the budget does include provisions to increase nursing home care beds, through conversions of existing hospital beds. The VA strongly advocates the use of conversions to meet the need for nursing home beds. Although the VA did not reach the expected results of conversions in FYs 1987 and 1988, we currently anticipate that 407 beds will be converted in FY 1989 and 207 in FY 1990.

Question: 14. The medical care budget for equipment reflects a decrease of approximately $24 million in replacement equipment for existing facilities, while additional equipment for existing facilities includes an increase of $31.5 million. Is this merely a shift in classification of equipment, and are sufficient funds included in this proposed budget to replace outdated equipment?

Answer: There was no shift in classification. The $24 million reduction in replacement equipment reflects a reprogramming to offset payroll increases in 1990. The $31.5 million increase in additional equipment reflects a restoration of funds that were reprogrammed in 1989. The combination of funds requested for replacement and additional equipment in 1990 results in a net increase above 1989 of over $7 million. Funds requested and planned in one equipment category can be obligated for the other.

Question: 15. Given the shortfall of funds for FY 89 of at least $435 million in the medical care budget, how can the DVA submit a budget for FY 90 which represents only $198.9 million above that requested for FY 89? Are you already preparing a supplemental request for the medical care budget for FY 90?

Answer: The FY 1990 Reagan Budget included a level of resources that would provide medical care to all veterans whose treatment VA is required by law to provide. Middle and higher income veterans may receive care on a resource available basis. In addition, the net increase of $198.9 million reflects savings to be generated by several medical care initiatives.

The President transmitted the 1989 supplemental to Congress on March 24, 1989. The VA has forwarded a 1990 amendment proposal to OMB for consideration.

Question: 16. How does DVA justify a decrease in Medical and Prosthetic Research to just above spending levels for FY 85?

Answer: The 1990 President's budget request for Medical and Prosthetic Research provides for funding of the highest priority research proposals while recognizing the overall budget restraint necessary to achieve the goal of deficit reduction.

Question: 17. Of the 2929 staff proposed to be hired by contract, what types of health care professionals are included?

Answer: The 1989 projected level of 2929 contractual FTEE includes the following types of health professional employees: Anesthesiologists, Certified Nurse Anesthesiologists, Clerical, Licensed Vocational Nurse/Licensed Practical Nurse, Registered Nurses, Nursing Assistants, Other Allied Health, Physicians, Perfusionists, Pharmacists, Psychiatrists, Radiologists, Therapists and Medical & Dental Residents.

Question: 18. You estimate proceeds of $535.2 million from non-recourse loan sales; if Congress enacts VA's legislative proposal on non-recourse sales, what would be the total value of loans sold for the $535.2 million and what is the amount of the assumed discount?

Answer: Under proposed legislation, the face value of non-recourse loan sales during 1990 is $939 million and is expected to net $535.2 million. The 43 percent discount, totaling $403.8 million, represents the face value of junior certificates backing the senior certificates and other related expenses associated with the sale. Taking into account the net present value of the junior certificates, the discount from the sale would be reduced to about 11 percent.

Question: 19. Please explain how the so-called "credit reform initiatives" have no impact in the veteran's ability to obtain guaranteed home loans?

Answer: As we understand the Administration's credit reform bill, it is intended that under credit reform the Loan Guaranty Program will continue normal program operations which will continue to be administered by the Department. To ensure the veteran's ability to obtain a guaranteed home loan, the budget authority for the subsidy amount would be a current, indefinite appropriation. The accompanying appropriation language would request "such sums as may be necessary are hereby appropriated".

Question: 20. You assume that interest rates on home mortgages are negotiable between borrower and lender. Please provide any evidence you may have to that effect.

Answer: Attached is a report on market conditions prepared by HUD. The report provides information on rates committed to by mortgage lenders on recent loan applications. The report of February 17, 1989, states that 10.50% was the most popular rate for FHA loans and the range of points for such loans was 1.00 to 2.50. Ten percent was reported as the second most popular mortgage rate with points ranging from 3.50 to 5.25. For conventional 30 year loans committed to in the same period the range of interest rates was from 10.38% to 11.13%. As can be seen lenders do offer different rates and different points for loans committed to during the same period of time. It depends on the lender, the borrower, and the individual circumstances of each transaction.

Question: 21. On the first page of your statement you state that your medical budget will allow you to treat all service-connected veterans, all former POW's and those exposed to toxic substances and radiation. You then state that it will also allow you to treat "all lower and middle income veterans" as well as "some higher income veterans" who apply. Please explain fully just who will be treated in terms of categories A, B, and C.

Answer: Traditionally, 95 percent of the VA's applicants for care have been category A veterans. The remaining 5 percent have been roughly divided between category B and category C. However, the regional penetrations have not been equal. In order to provide an equitable distribution of access to care nationally, within available funds, the CMD decided to limit all Regions to the level of the lowest Region. Region 3 had the lowest percent of category B and C patients; (1.5 percent for inpatients and 8.3 percent for outpatients); so that has become the

U.S.DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON,D.C. 20410-8000

OFFICE OF THE ASSISTANT SECRETARY FOR HOUSING-
FEDERAL HOUSING COMMISSIONER

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FEB 22 1989

February 17, 1989

MEMORANDUM FOR: James E. Schoenberger, General Deputy Assistant
Secretary for Housing, HD

FROM: James B. Mitchell, Director, Financial Policy Division, HPFP

SUBJECT: Monitoring Mortgage Interest Rates,
Friday, February 17, 1989

I. Overview

Even though the average price of secondary mortgage market transactions reported this week fell by over three-quarters of a point, most of the leading mortgage bankers surveyed today were surprised and somewhat perplexed that the mortgage market has continued to show such resilience. This bewilderment was perpetuated by several pieces of data released this week showing continued strong economic growth, as well as tangible evidence that the Federal Reserve is further tightening credit. Most of the respondents, however, are now convinced that long-term rates at any time will rise significantly, i.e., "the other shoe will drop." Therefore, they are closely monitoring the market, particularly looking for signs of a collapse in current price support levels leading to the subsequent establishment of a new, but lower trading range.

Some representative comments:

"All the economic numbers this week provide solid evidence that the economy has a strong head of steam. Retail sales, industrial production, and plant utilization, showed strength. Housing starts jumped 8 percent — however the warm weather may have produced an aberration, and building permits, a future indication of starts, actually declined. Even the trade numbers showed economic strength, particularly the 6 percent increase in exports. Nothing yet gives reason to think the economy is slowing down. Consequently the Federal Reserve will keep pressure on interest rates. In fact, they were actively draining funds from the banking system. Frankly, the odds are slim to none that GNMA prices will continue to hold. It has been very surprising that the market has exhibited the strength it has so far."

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"Overall, this week we stayed within a trading range, in spite of all the economic data that came out. Tuesday's Retail Sales were strong, so the market fell off and then rallied. Wednesday's capacity utilization was high enough to concern economists about inflationary pressure. Thursday's strong housing starts were attributed to unseasonably warm weather, so there was a bit of a short-covering rally to get ready for today's trade number. The trade deficit came in a little worse than expected, but hasn't raised much concern. The fact that the Bundesbank did not raise its rate and the Fed, therefore, found it less imperative to raise the discount rate, may have helped the rally Thursday. Most economists continue to have a bearish outlook because of inflationary pressure."

"Everyone was waiting for today's trade data, but now that it has been released, the market has gone asleep. Trading is thin, with some people taking off early to enjoy the three-day weekend. Many mortgage bankers pay a great deal of attention to the price of "T" bond options on the Chicago Board of Trade. March contracts have good support levels at $88-9/32nds. If this support level is broken through, there is minor support at $88.74, then support again at $87.00. What this means is that the prices of Ginnie Maes, Fannie Maes, and Freddie Macs could go down a full point before a new trading range is established. With constant pressure on short-term rates by the Fed, the new trading range of mortgage securities could happen very soon. This would put GNMAs in about a 3-1/4 point discount market, or not quite enough to trigger an 11.00 percent rate. But, a further round of tightening would produce such an event."

"The market has been fairly quiet, a little weak, and trending downward. We are staying fairly well covered. If anything, the economic news this week will only stiffen the Fed's resolve to tighten interest rates further. I sure hope that the Fed is successful in bringing about a soft landing, but I doubt the monetary levers can be maneuvered so adeptly. Based on the past, however, they will tighten too much for too long, then will overcompensate by loosening too much too soon. Housing, unfortunately, suffers the most on that roller coaster. Those buying bonds could find themselves looking at good capital appreciation when the interest rate decline does come."

"This week we took in 1,231 applications for $106 million, the biggest week since March of 1988. Since most of our business is Governments, the average mortgage amount was fairly low at $86,000. Increased applications stem from our aggressive pricing policies. Compared to a year ago, business is higher in our Maryland Regional Office, which includes Virginia, as well as in our Florida and Chicago Regional Offices. The Northeast area is holding its own, and the West is struggling to stay even with last year. The main constraint to FHA production is the loan limits. They really put us at a disadvantage in the Northeast and Maryland areas, but they are not as much a problem in the mid-West/Chicago area."

II. Findings

A. Primary Mortgage Market

1) FHA 30 year Loans

Ninety-three percent of the companies reported that 10.50 percent was the most popular commitment rate for FHA 30-year level payment loans in the primary market. The range of points quoted for the 10.50 loans was 1.00 to 2.50. The average was 1.95 points. The average effective rate this week was 10.80 percent, up 5 basis points from the previous survey.

A majority of the companies reported a 10.00 percent commitment rate as their second most popular mortgage rate. Points on these 10.00 percent mortgages ranged from 3.50 to 5.25, with an average effective rate of 10.68 percent, up 8 basis points from the last survey.

2) FHA 15 year Loans

Fifty-six percent of the companies reported a commitment rate of 10.50 percent as the most popular rate for FHA level payment 15-year loans. The range of points quoted for these loans was zero to 1.25. The average was 0.48 points.

3) FHA GPM Loans

Ninety-three percent of the companies making quotes for FHA Section 245 GPM loan commitments reported 10.75 percent as the dominate rate for such loans. The range of discounts was 0.75 to 4.25 points, with an average of 2.31 points. The average effective rate this week was 11.11 percent, up 5 basis points from the last survey.

4) FHA ARMs

The percentage of companies offering FHA ARMs this week was 70 percent, compared to 68 percent the previous survey. Quotes this week ranged from 8.50 percent plus 2.13 point to 10.88 percent plus 1.00 point. Of those offering ARMs, 63 percent quoted 9.50 percent mortgages and 21 percent quoted 9.00 percent mortgages.

5) VA Loans

The average points in the primary market for commitments on VA guaranteed loans, subject to the 10.50 percent maximum rate, was 1.97 points. Quotes this week were from 1.00 to 2.50 points. The effective rate on commitments to close loans at the administered ceiling rate averaged 10.80 percent, up 5 basis points from the previous survey.

6) Conventional 30 year Loans

The range of contract interest rates quoted on 80 percent loan-to-value conventional mortgages was 10.38 percent (plus zero points) to 11.13 percent (and no points). The average effective rate was 10.88 percent, up 3 basis points from the last report.

7) Conventional 15 year Loans

The range of contract interest rates quoted on 80 percent loan-to-value ratio 15-year conventional loan commitments was 10.00 percent (plus 0.50 points) to 11.13 percent (and zero points). The average effective rate was 10.81 percent, up 4 basis points from the last survey.

8) Conventional ARMs

One hundred percent of the companies were offering conventional ARMs, up from 93 percent the previous survey. Interest rates ranged between 7.88 percent (plus 2.00 points) and 10.50 percent (plus zero points). One year ARM loans were the predominant ARMs offered by the mortgage companies.

B. Secondary Mortgage Market

1) FHA/VA Fixed Rate Loans

A total of $237.4 million in FHA/VA fixed payment loan commitments was acquired by 20 companies, compared to $234.6 million purchased by 21 companies from the last survey. All of the FHA/VA commitments negotiated were acquired in the GNMA market. Commitments obtained this week encompassed the following mortgage rates for 30-year loans: 9.50, 10.00, 10.50, 11.00, and 11.50 percent.

The largest volume of 30 year level payment commitments was for 10.50 percent loans (73 percent of the total). For the 10.50 percent loans, prices ranged from $97.75 to $98.25. The average was $98.02 which results in a 10.81 percent yield. Major 30-year level payment transactions were:

Contract Interest Rate	Volume (millions)	Percent of Total Transactions	Average Price
10.00	$22.5	9	$95.54
10.50	174.0	73	98.02
11.00	23.5	10	100.25

Commitments of $4.7 million were obtained for 15-year loans in the GNMA market.

2) FHA GPM Loans

No GPM loans were sold this week.

3) FHA ARM Loans

$3.5 million in FHA ARM loans were sold this week.

4) Conventional Loans

Twenty-two companies obtained a total of $116.5 million in commitments for fixed-rate conventional loans this week. Of these commitments, $83.0 million came from FNMA, and $33.5 million from the Federal Home Loan Mortgage Corporation. The commitments under discussion include both 15- and 30-year fixed products. The average yield on 30-year loans was 10.84 percent. $5.0 million in conventional ARM loans were sold this week to private investors.

C. Trends in the Supply and Demand for Funds

1) Commitment Coverage

a) The average time it would take to exhaust the supply of outstanding commitments for FHA/VA loans at the current rate of production rose to eight weeks (1.98 months).

b) All of the companies indicated an adequate supply of conventional funds for level-payment mortgages, given current demand. Commitments would cover loan production for between seven and eight weeks (1.94 months).

c) An adequate supply of conventional ARM loan funds was affirmed by 100 percent of the companies. The average commitment coverage stayed between seven and eight weeks (1.84 months).

2) Secondary Market Conditions

Fifty percent of the companies company reported a tightening supply of FHA/VA, and conventional funds, compared to 82 percent of the companies reporting such a supply condition in the last survey. This week, 42 percent reported a stationary supply, and 8 percent noted a loosening supply of funds for various types of loans.

3) Application Volume

Stronger loan demand for 30-year fixed rate FHA/VA loans was reported by 41 percent of the respondents, compared to 37 percent having the same situation the previous survey. Thirty-three percent reported that the loan demand was stable, while 26 percent had a lower application volume this week. For FHA 15-year loans, applications were up for 42 percent, while 31 percent reported a stable volume. FHA ARM loan applications increased for 36 percent of the companies, while another 36 percent had an unchanged volume from the last survey. Thirty-seven percent of the companies had a greater volume of conventional fixed rate loans and 32 percent also experienced a rise in the number of ARM loans this week.

4) Types of Loans in Pipeline

The current production product mix varied from company to company. A distribution of loan applications currently being processed by the respondents is presented below.

	Percent Distribution This Week		Prior Survey
	range	"Average"	"Average"
Total		100%	100%
FHA/VA vs.	3-98	53	52
Conventional	2-97	47	48
FHA/VA			
FHA/VA 30 year Fixed Rate Loans	75-100	92%	93%
FHA/VA 15 year Fixed Rate Loans	0-15	5	5
FHA/ARMs	0-10	3	3
Subtotal		100	100
Conventional			
Conventional 30 year Fixed Rate Loans	10-100	66%	69%
Conventional 15 year Fixed Rate Loans	0-15	6	7
Conventional ARMs	0-88	28	24
Sub Total		100	100

The foregoing summary is based on a poll of 30 of the largest mortgage banking firms conducted on February 17, 1989.

Attachments

Money, Banking, and Credit

A sharp eye, a steady hand and nerves of steel. In many circles such traits are the mark of excellence. They are not often the traits one thinks of as prerequsites for Federal Reserve Board members. Nonetheless one hopes that the board members have them in abundance, for now is not the time to twitch.

For about the last year, with a focus on incipient inflation, the Fed has kept pressure on short term interest rates. Tightness was maintained this week by the Fed's early action of $2.2 billion in 2-day matched sales on Wednesday, followed by another $2.4 billion in 5-day matched sales on Thursday. These operations were executed with the Funds rate at 9.32%.

Despite this tightening, one might, without looking very hard, see signs that further tightening is advisable. In December, capacity utilization rose to 84.4%, retail sales increased 0.6% and industrial production rose 0.3%. This view is reenforced by the lack of movement in long term interest rates. While their failure to rise could indicate that demand for long funds has decreased so that the amount demanded is met with a reduced supply, historic investment patterns and the strength of the economy shown by other data rebut this. These intimate an unchanged demand, satisfied at an unchanged rate. If so, and long rates do drive investment behavior, then short rates must be tightened until longer rates begin to move.

It is also certain that the Fed recalls Milton Friedman's caution that "monetary policy operates with long and variable lags." The 0.9% increase in inventories in December and the ongoing epidemic of bank and S&L failures can only sharpen the current Fed's recollection that most recessions have been caused by the Fed doing a little too much, a little too late. The question of how much more to tighten, given that the full effects of recent tightening are not known, involves no small amount of prescience.

The mixed signs that the economy presents, and the perceived sensitivity of an economy in this state offer an explanation of the large gap between the Federal Funds rate and the Discount rate. While much is made of the psychological implications of discount rate changes, it is worth remembering that it provides a support for individual banks. It provides a mechanism for rapid loosening at the level that Federal Funds tightening immediately affects. Through discounts, the Fed can provide low interest money to small banks that might court failure if forced to pay the rate charged on the Federal Funds. The large portion (99% this week) of Fed discounts claimed by smaller banks supports this proposition.

HFFP: LASKY:mdl 2/17/89 755-7270 (Credit)

ECONOMIC INDICATORS   TELEPATE PEPCENT CHANGE -- UNLESS NOTED

17-Feb-89 08:57 AM	JAN	DEC	NOV	OCT	SEP	AUG	JUL	1988 JUN	MAY	APR	MAR	FEB	JAN
New this week: *													
LEADING INDICATORS..........		0.6	-0.2	0.5	-0.3	0.5	-0.7	1.4	-0.8	0.5	0.2	1.5	-1.1
TRADE BALANCE ($BLN)........*		-11.9	-12.2	-10.3	-10.7	-12.3	-9.5	-13.2	-9.8	-10.7	-11.7	-14.4	-11.3
UNEMPLOYMENT (% CIVILIAN)...	5.4	5.3	5.4	5.3	5.4	5.6	5.4	5.3	5.6	5.4	5.6	5.7	5.8
NON FARM PAYROLL (000)......	+408	+221	+404	+238	+304	+169	+200	+532	+221	+249	+296	+517	+174
PERSONAL INCOME.............		0.9	-0.2	1.7	0.5	0.3	0.7	0.6	0.5	0.1	1.1	0.6	0.3
REAL EARNINGS...............			-0.8	0.7	0.5	-1.3	0.7	-0.2	-0.6	1.0	-0.6	0.1	0.6
CONSUMER CREDIT ($BLN)......		$5.44	$4.48	$3.91	$1.90	$5.32	$3.62	$5.43	$2.98	$3.65	$5.19	$5.04	$6.24
RETAIL SALES...............*	0.6	-0.1	0.9	1.6	-0.3	-0.1	0.1	0.6	0.3	-0.4	1.7	0.6	-0.2
BUSINESS INVENTORIES.......*		0.9	0.4	0.0	0.9	1.1	0.7	0.8	0.7	0.5	0.3	0.4	0.7
FACTORY ORDERS..............		4.1	0.3	2.0	-1.9	1.2	-3.6	5.4	-0.6	1.5	1.6	-0.8	-0.6
DURABLE GOODS ORDERS........		6.4	0.1	2.9	-2.9	5.7	-7.4	8.7	-1.9	1.8	0.8	0.1	-1.2
INDUSTRIAL PRODUCTION.......*	0.3	0.5	0.3	0.5	0.2	0.3	1.2	0.3	0.5	0.4	0.2	0.2	-0.4
CAPACITY UTILIZATION (%)....*	84.4	84.4	84.2	84.0	[illegible]	83.0	83.8	83.0	82.9	82.6	82.4	82.4	82.6
CONSTRUCTION SPENDING.......		2.5	1.0	-0.2	0.7	[illegible]	0.7	-1.5	0.8	-0.2	1.5	0.4	-2.8
HOUSING STARTS..............*	8.0	0.1	1.6	3.1	[illegible]	[illegible]	1.4	4.4	-12.6	3.1	2.3	9.6	-1.9
NEW HOME SALES		0.6	-7.9	4.4	[illegible]	2.1	-0.1	6.7	-0.3	1.1	1.2	14.1	-10.3
EXISTING HOME SALES.........		11.4	0.0	-1.1	-1.1	2.2	[illegible]	5.3	3.1	5.7	2.5	2.5	-3.6
PRODUCER PRICE INDEX........	1.9	0.4	0.3	0.0	0.4	0.6	0.5	0.4	0.5	0.4	0.6	-0.2	0.4
CONSUMER PRICE INDEX........		0.3	0.3	0.4	0.3	0.4	0.4	0.3	0.3	0.4	0.5	0.2	0.3
GNP.........................			4th Q 2.0			3rd Q 2.5			2nd Q 3.0			1st Q 3.4	
GNP DEFLATOR................			4th Q 4.7			3rd Q 4.7			2nd Q 5.5			1st Q 1.7	

Due out next week: Consumer Price Index, Real Earnings (Wed 2/22), Durable Goods Orders (Thu 2/23), Existing Home Sales (Fri 2/24)

Table A

Mortgage Company Weekly Opinion Poll of Mortgage Market Conditions

	Week Ending Feb. 17, 1989	Week Ending Feb. 10, 1989	Week Ending Feb. 3, 1989	Week Ending Jan. 27, 1989	Week Ending Jan. 19, 1989	Week Ending Jan. 13, 1989	Week Ending Jan. 6, 1989
Number of Companies in Survey	30	30	30	30	30	30	26
A. **Primary Market**							
1. FHA 203 loans							
a) contract rate %	10.50	10.50	10.50	10.50	10.50	10.50	10.50
b) range of discount points	1.00-2.50	.25-2.50	.25-2.25	0-2.25	0-2.50	.25-2.75	1.25-2.88
c) average points	1.95	1.59	1.08	1.00	1.14	1.65	2.39
d) effective rate or yield (%)	10.80	10.75	10.67	10.65	10.68	10.75	10.87
2. FHA GPM loans							
a) contract rate %	10.75	10.75	10.75	10.75	10.75	10.75	10.75
b) range of points	.75-4.25	.50-3.25	0-3.38	0-3.00	.25-3.50	.50-4.00	1.25-4.50
c) average points	2.31	1.99	1.47	1.33	1.66	2.04	2.87
d) effective rate or yield (%)	11.11	11.06	10.98	10.96	11.01	11.07	11.20
3. VA loans							
a) contract rate %	10.50	10.50	10.50	10.50	10.50	10.50	10.50
b) range of points	1.00-2.50	.25-2.50	.25-2.25	0-2.25	0-2.50	.25-2.75	1.25-2.88
c) average points	1.97	1.59	1.08	1.03	1.21	1.65	2.38
d) effective rate or yield (%)	10.80	10.75	10.67	10.66	10.69	10.75	10.87
4. Conventional 80% loans, 30 years							
a) range of interest rates	10.38-11.13	10.38-11.13	10.38-11.00	10.25-11.00	10.50-11.00	10.25-11.00	10.38-11.38
b) average effective rate	10.88	10.85	10.75	10.73	10.79	10.86	11.01
B. **Secondary Market** - terms on commitments received for 2-4 month deliveries							
1. FHA Section 203 loans							
a) contract rate	10.50	10.50	10.50	10.50	10.50	10.50	10.50
b) range of prices	97.75-98.25	97.94-99.81	98.75-99.06	98.63-99.16	97.97-98.94	97.56-98.63	97.25-98.00
c) average GNMA price	98.02	98.84	98.92	98.87	98.54	98.00	97.68
d) average composite price	98.02	98.84	98.92	98.87	98.54	98.00	97.68
e) average yield	10.81	10.68	10.67	10.67	10.72	10.81	10.86
f) new commitments (millions)	$237	$235	$189	$177	$133	$197	$206
g) most important buyers							
1)	GNMA	GNMA	GNMA	GNMA	GNMA	GNMA	GNMA
2)	-	-	-	-	-	-	-
3)	-	-	-	-	-	-	-
2. Conventional loans (fixed rate mortgage)							
a) range of yields	10.49-11.34	10.40-10.79	10.37-11.18	10.23-11.14	10.39-11.17	10.32-11.08	10.53-11.16
b) average yield	10.84	10.61	10.63	10.60	10.73	10.74	10.81
c) new commitments (millions)	$117	$146	$122	$123	$78	$115	$125
d) most important buyers							
1)	FNMA	FNMA	FNMA	FNMA	FNMA	FNMA	FNMA
2)	FHLMC	FHLMC	FHLMC	FHLMC	FHLMC	FHLMC	FHLMC
3. Conventional loans (ARM's)							
a) new commitments (millions)	$5M	None	None	None	None	$1	None
b) most important buyers	Private Investor	-		FNMA			

* Less than $500,000

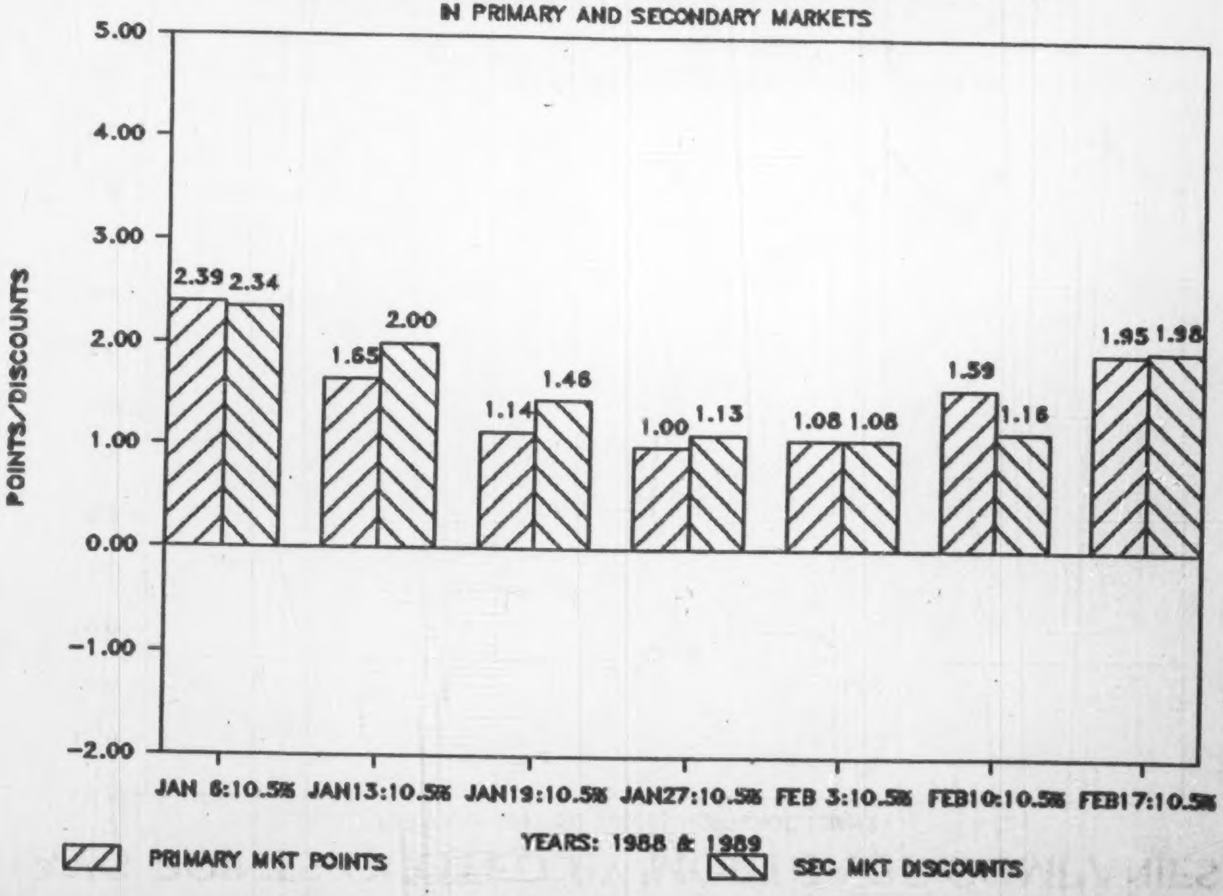
E = Estimated on the basis of daily closing prices for appropriate actively traded benchmark mortgage-backed securities.

Table A (continued)

	Week Ending Feb. 17, 1989	Week Ending Feb. 10, 1989	Week Ending Feb. 3, 1989	Week Ending Jan. 27, 1989	Week Ending Jan. 19, 1989	Week Ending Jan. 13, 1989	Week Ending Jan. 6, 1989
C. Adequacy of Funds (percent of firms reporting adequate supply of funds in relationship to current demand)							
1. FHA Section 203							
a) adequacy percentage	100%	100%	100%	100%	100%	100%	100%
b) commitment coverage (months)	1.98	1.93	2.04	1.85	1.92	2.09	2.03
2. Conventional							
a) adequacy percent	100%	100%	100%	100%	100%	100%	100%
b) commitment coverage (months)	1.94	1.88	1.98	1.78	1.92	2.10	1.99
D. Trend in Supply of Mortgage Funds Compared to Last Week (% distribution)							
1. FHA Section 203							
a) tightening	50%	82%	32%	14%	3%	0%	63%
b) stationary	42	18	52	39	36	39	30
c) loosening	8	0	16	47	61	61	7
2. FHA GPM loans							
a) tightening	50%	82%	32%	14%	3%	0%	63%
b) stationary	42	18	52	39	36	39	30
c) loosening	8	0	16	47	61	61	7
3. Conventional loans							
a) tightening	50%	82%	32%	14%	3%	0%	63%
b) stationary	42	18	52	39	36	39	30
c) loosening	8	0	16	47	61	61	7
E. Trend in Demand for Funds Compared to Last Week (percent distribution)							
1. FHA Section 203							
a) weaker/lower applications	26%	30%	12%	7%	19%	37%	73%
b) stationary/about same as last week	33	33	36	26	22	48	23
c) stronger/higher volume of application	41	37	52	67	59	15	4
2. Conventional loans (Fixed Rate)							
a) weaker/lower applications	26%	30%	16%	7%	15%	37%	73%
b) stationary/about same as last week	37	33	32	30	22	48	23
c) stronger/higher volume of applications	37	37	52	63	63	15	4
3. Conventional loans (ARM's)							
a) weaker/lower application	26%	29%	16%	7%	18%	31%	68%
b) stationary/about same as last week	37	32	32	33	18	45	18
c) stronger/higher volume of applications	33	32	48	56	57	14	3
d) no applications	4	7	4	4	7	10	11

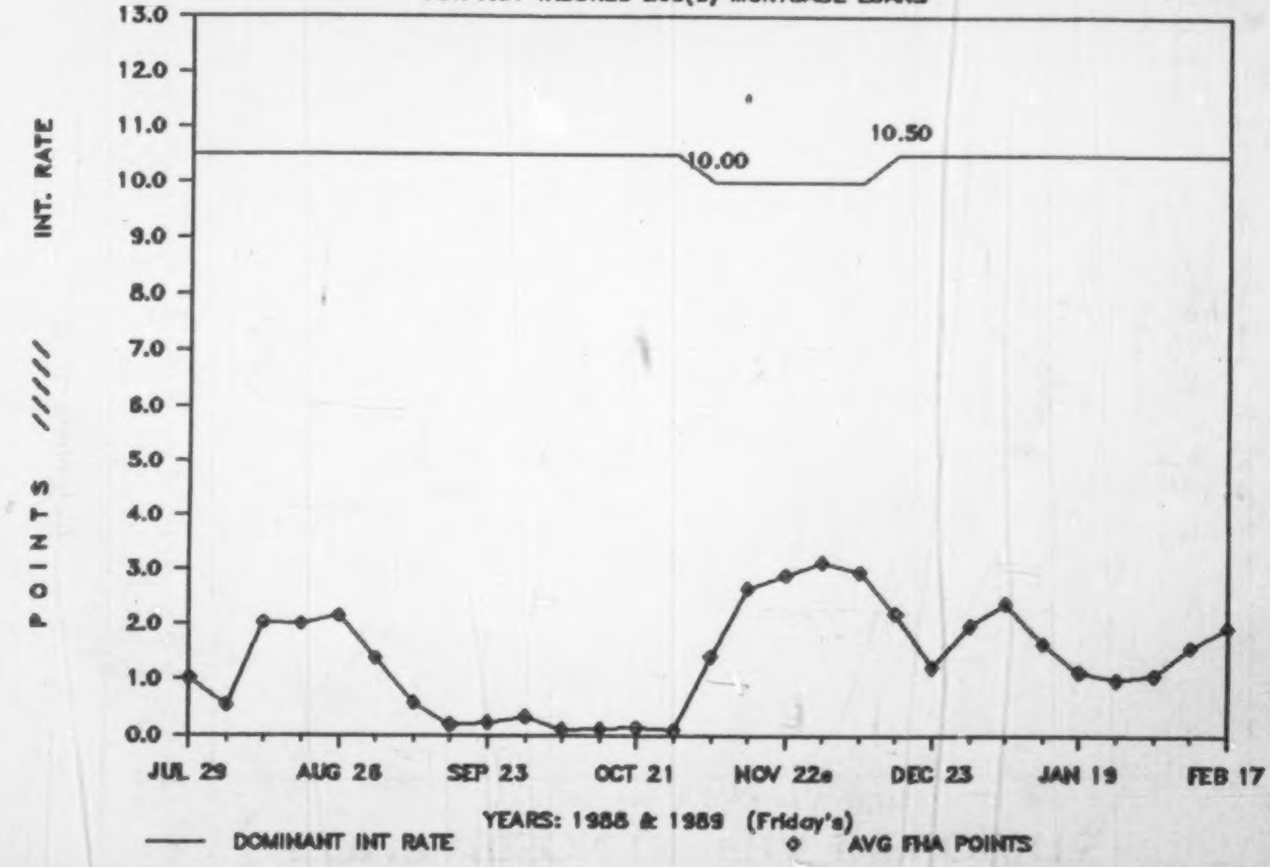
COMPARISON OF FHA DISCOUNTS

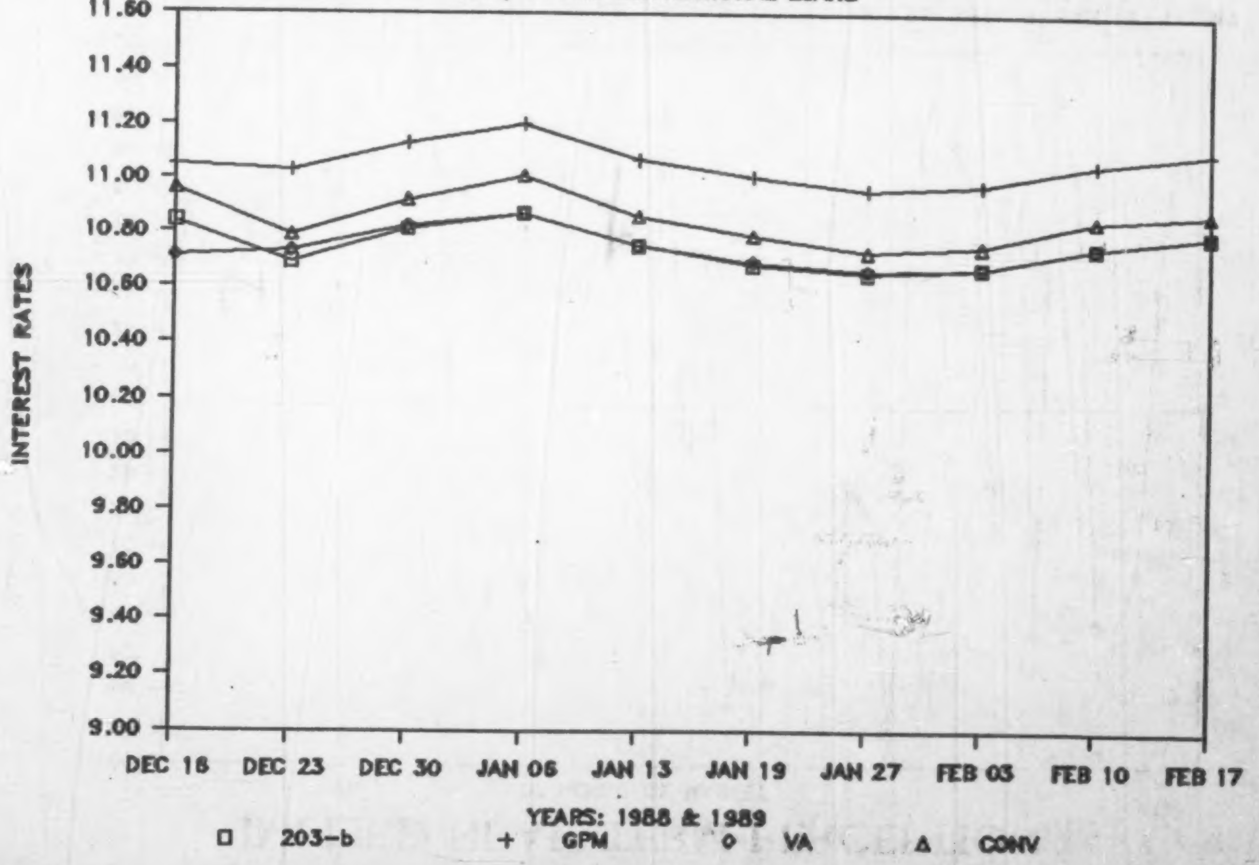
IN PRIMARY AND SECONDARY MARKETS



AVG POINTS QUOTED BY MORTGAGE COMPANIES

FOR FHA-INSURED 203(b) MORTGAGE LOANS



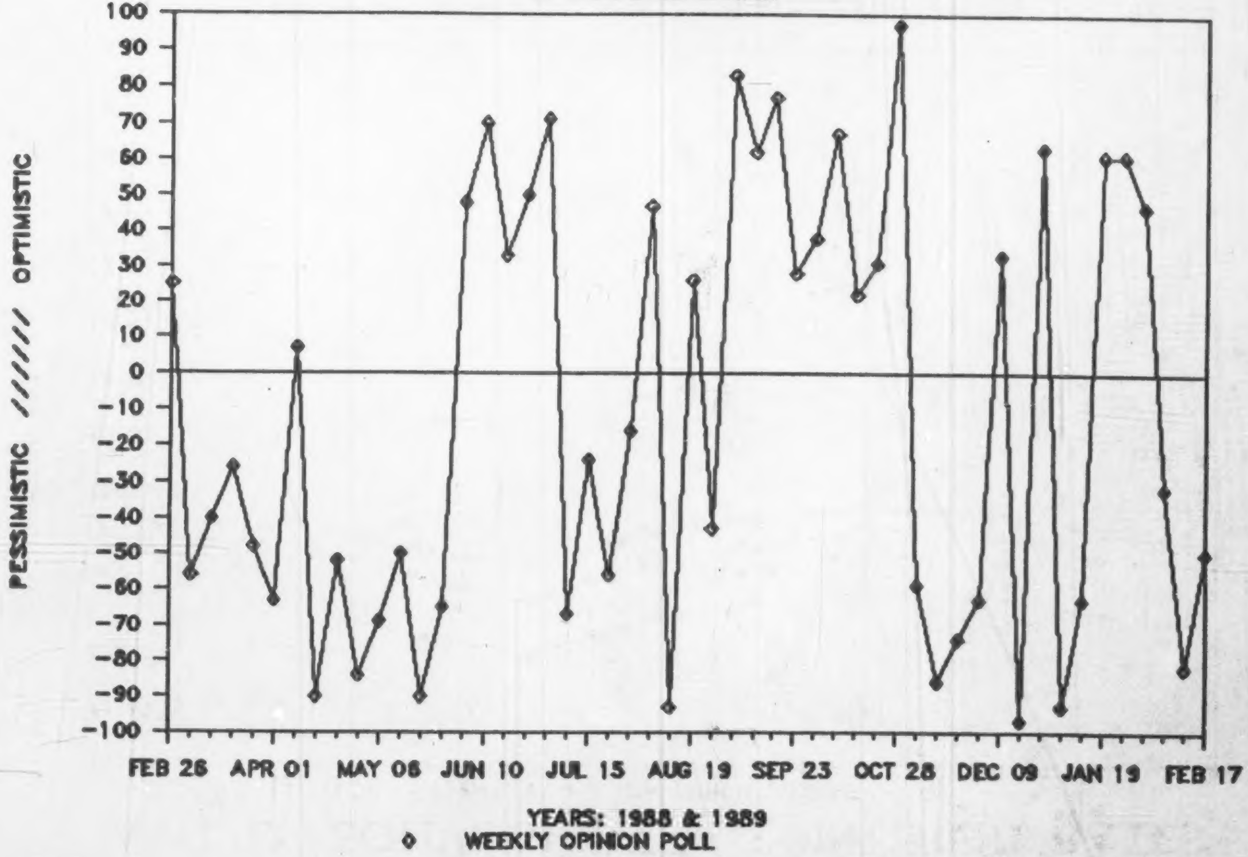


AVG. EFFECTIVE MORTGAGE INTEREST RATES

FHA, VA and CONVENTIONAL LOANS

IMPLIED NEAR-TERM PERCEPTION

OF MORTGAGE MARKET



John Goodman	Federal Reserve
Keith Pedigo	Veterans Administration
Jim Sharera	Treasury
Barry Wides	OMB
Richard Pickering	FHLBB
Jim Boland	FHLBB
Gerard Keffer	Census Bureau
Charles Hanson	OMB
William J. Maroni	Old Executive Office Building
M. Schussheim	Congressional Research Office
Barbara Miles	Congressional Research Office
Angelo A. Vigna	Federal Home Loan Bank of New York
Nina Shepherd	Congressional Budget Office
Edward Golding	FHLBB
Thomas Simpson	Federal Reserve
David Lund	Department of Commerce
D. Laufenberg	Federal Reserve
Ned Newland	Joint Tax Committee
Sylvia Lucas	Federal Reserve, Stop 89
David Pinson	Council of State Hsg. Agencies

TABLE A ONLY

Kathy Covell	CIMA (release and Table A only)
Paul Van Valkenburg	Drexel Burnham
FNMA	
Mortgage Bankers Association	
Mortgage Commentary	
Mortgage Market Insight	
Inside Mortgage Finance	
Southmark Mortgage Corp.	Katie Wojciechowski (Release and Table A only)

goal of the other Regions. The Regions have been given this percentage as an aggregate goal; not as a goal for each medical facility. Therefore, the percentages of Bs and Cs at various facilities within a Region may vary considerably for valid programmatic reasons.

Question: 22. Please elaborate on your proposal to have co-payments made by middle or higher income nonservice-connected veterans. If such payments are to be made, how would you react to such veterans having entitlement to care as opposed to it being limited to available resources?

Answer: Congress, in the last two sessions of the 100th Congress, has mandated through legislation that the VA provide medical care to service-connected veterans and to low-income nonservice-connected veterans. The co-payment legislative proposal builds upon the current law requiring higher income veterans to pay deductibles for care. It is consistent with current developments in the private health care market where virtually everyone, including Health Maintenance Organizations, are now requiring some level of copayments. The co-payment legislative proposal would assess a minimal fee from category B and C veterans for medical care provided as an inpatient, outpatient and for prescriptions. These fees will encourage prudent use of VA facilities, while at the same time, not adversely impacting the vast majority of veterans who need medical services. To the extent usage is more prudent, such as reducing the stocking-up on prescriptions as indicated by Acting Administrator Harvey earlier this year before the House Veterans' Affairs Committee, more resources will be available to serve veterans in need of our care. We do not believe making care mandatory for middle or higher income veterans is a realistic proposal.

Question: 23. How much money did you request of OMB for General Operating Expenses for the Department of Veterans Benefits as compared to the figures in the 1990 Budget? What is going to be the effect on claims processing if the budget request prevails?

Answer: The Veterans Benefits Administration requested and received the following from OMB for the 1990 budget:

	1989 ($000)		1990 ($000)	
	FTEE	BA	FTEE	BA
1990 OMB Budget Request	12,898	$556,043	12,418	$563,813
1990 President's Request	12,650	$515,859	12,100	$548,829

The proposed FY 1990 budget will essentially sustain the current level of performance.

Question: 24. The VA appealed the Fiscal Year 1990 budget and lost. How much did the Department of Medicine and Surgery want to appeal for and how much did the then Administrator actually appeal to OMB and what were the differences?

Answer: We respect your desire for information on the budget process, but must insist on the maintenance of open communication within my department which requires confidentiality particularly on budget matters. If all written and oral communications made in the decision-making process are subject to review and public examination, there would be a chilling effect on the candor in the opinions provided me in reaching decisions on budget matters.

Question: 25. You mention "new medical technology" that will increase productivity and improve services. Please elaborate.

Answer: The term "new medical technology" is a broad general term that encompasses all aspects of improvements in clinical management of patients, improved delivery and support systems, and improved physical environment for health care delivery. For many years, advances in medical science and health care delivery systems have caused improvements in individual employee productivity.

Question: 26. You mention a number of legislative proposals in a number of areas. If the Congress does not pass them, how much total money will need to be added to the 1990 budget?

Answer: The 1990 Reagan budget request for the Department of Veterans Affairs reflects a net savings legislation of $83,812,000. The proposals consist of three categories of initiatives: savings initiatives, cost of living rate increases for service-connected veterans and their dependents, and the resubmission of Credit Reform initiative. The majority of the legislative proposals for the Department are savings initiatives for several programs which would both improve their operations and help reduce their expenses. If these proposals were not passed, the effect would be to add back the savings to these programs, and several initiatives would not be implemented in 1990. The following programs include proposed legislative savings initiatives for a total of $1,240,354,000:

Loan Guaranty Revolving Fund	$-1,112,900,000	1/
General Operating Expenses	- 4,400,000	
Medical Care	- 718,000	
Burial Benefits and Miscellaneous Assistance	- 36,500,000	
Proprietary Receipts (Third Party Reimbursements and Co-Payments	- 85,836,000	

There are two legislative proposals that effect rate increases for veterans benefits. The legislative proposal for Compensation grants an increase in disability compensation, including the survivors' dependency and indemnity compensation (DIC) intended to compensate for an increase in the cost of living by 3.6 percent, effective December 1, 1989. If this proposal is not passed, veterans who are being compensated would not receive a COLA increase while pensions and social security recipients would. The second proposal increases dependents' assistance allowances and vocational rehabilitation subsistence allowances by 5 percent, effective January 1, 1990. Educational assistance benefits were last increased in 1984. The total of these two proposals is $323,300,000.

The Administration is resubmitting a legislative proposal that will identify the grant equivalent subsidy of Federal Credit Programs. The proposal will require subsidy appropriations to a central revolving fund at Treasury prior to making a loan. VA will continue to administer the program, but the Treasury will be the central financing mechanism for new Federal loans. The subsidy appropriation proposal for the VA is $833,242,000, assuming a 3.8 percent fee.

1/ The Reagan Budget proposed increasing the origination fee on housing guarantees from one percent to 3.8 percent. The Bush Budget proposes continuing the funding fee at one percent.

Question: 27. You send reports to Congress on collections from 3rd party insurers. Some Medical Centers have collected considerable amounts of money while some have collected very little. Why is this?

Answer: As you have noted, the amounts of collections among medical centers are wide ranging. This may be attributable to several factors. Some of the payments by the insurers are reduced because of the deductible that must be reached by the insured before "full" coverage (even though it is a percentage of the bill) begins; other insurance companies only routinely pay a percentage of the bill presented for payment. Some insurance companies have been reluctant to pay and recognize the VA as a medical care provider. Staffs at the involved medical centers and VA Central Office have been working with District Counsel staffs to overcome these obstacles with the insurance companies. Finally, the emphasis placed on the third party collection program varies by medical facility. Although the collection amounts are wide ranging, the third party collection program continues to be one of the highest priorities within the VA and we are working to encourage all facilities to share information on their experiences in this area.

Question: 28. The budget proposes a 5% increase in allowances for GI Bill benefits for dependents and for disabled veterans receiving vocational rehabilitation. Is there a reason why veterans going to school under the Vietnam GI Bill are not included in this 5% increase?

Answer: The referenced 5 percent rate increase included in President Reagan's budget did not include an increase for the Vietnam-era GI Bill education benefit program since the proposed increase would have taken effect after that program had terminated by operation of law on December 31, 1989. (38 U.S.C. Sec.1662(e).)

NOVA NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION
6728 Old McLean Village Drive
McLean, Virginia 22101
Phone (703) 556-9222

March 20, 1989

The Honorable G.V. (Sonny) Montgomery
Chairman
U.S. House of Representatives
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Montgomery:

In response to your letter of February 17, 1989, requesting an answer to the Honorable Bob Stumps' question of February 9, 1989 – "Please provide the Committee any additional information you may have about VA nurses working overtime at rates of pay which are less than their basic pay." -- the following is offered:

The issue of cap on the overtime rate is one our members have brought to our attention because it seems to defy their belief in common sense and fair play. The situation they describe is as follows: The overtime rate is currently limited to $20 per hour. This means a nurse is paid the overtime rate of 1.5x the usual hourly rate until the maximum of $20 per hour is reached. Thus, a nurse who is full grade step 5 receives 1.5x the hourly rate. This percentage is gradually reduced for each step thereafter until Senior grade step 7 where the nurse would, in fact, make less at the overtime rate than the senior grade step 7 regular rate. This situation is made worse in areas with special salary rates. For example, the San Francisco Bay Area special salary rates create a situation wherein Intermediate grade nurses step 5 and above will make less at the overtime rate than their basic rate of pay.

The resulting situation is the overtime rate is so unfair nurses are frequently given comp time 1 hour for 1 hour of overtime that is needed to staff the hospitals and contributes to a continual shortage of staff available to care for patients.

The NOVA position is attached.

Cordially,

Claudette Morrissey

Claudette Morrissey
President

NOVA NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION

6728 Old McLean Village Drive
McLean, Virginia 22101
Phone (703) 556-9222

NOVA'S RECOMMENDATIONS TO REMOVE PAY CAP ON OVERTIME PAY FOR NURSES

Background

Current regulations limit overtime rates for work in excess of 40 hours per week to a specified cap even though the nurses' actual overtime rate would be in excess of that amount.

For Title 5 nurses, 5 U.S.C. 5542 (a) limits OT pay to hourly rate for GS-10/1, currently $17.78/hour.

For Title 38 nurses, 38 U.S.C. 4107 (e) (5) limits OT pay to hourly rate for Intermediate/1, currently $19.59/hour.

Both laws provide the opportunity for equivalent time off (compensatory time) rather than pay for overtime.

Recommendation

That the cap on overtime pay be removed and language be adopted whereby both Title 38 and Title 5 nurses would be paid for overtime work at the rate of 1.5 times actual hourly salary rate without regard to imposed caps (i.e., remove caps).

Comment

This modification would significantly boost morale and would remove the current disincentive for higher graded employees to work overtime.

This modification would make VA pay practices more consistent with private sector practices.

This very positive response will help with the retention of experienced nurses and will help alleviate the growing crisis over nurses leaving the VA for private sector jobs.

Each nurse retained in the system represents a cost savings from in-service education which does not have to be provided ranging from $5,000 to $12,000 depending on the position.

Source: Much of the above has been drawn from the VA's Preliminary Report (July 1987) by the Task Force on Recruitment and Retention of non-physician health care workers.

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Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 21 1989

In Reply Refer To:

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed is the revised response to the Honorable Lane Evans question #6 concerning projected savings for each type of service to be privatized. This is in reference to your letter dated April 26, 1989 requesting a more appropriate response to the question.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosures

"America is #1—Thanks to our Veterans"

CONGRESSMAN EVANS

Question: 1. The budget proposes establishing 5 additional Post-traumatic Stress Disorder programs in 1990. How many veterans can be treated annually by these five additional programs? Including the 5 new proposed new PTSD programs, how many veterans can receive treatment for PTSD from the VA next fiscal year utilizing all PTSD programs, both inpatient and outpatient?

Answer: Our projections for the number of patients that would be treated annually by these 5 additional PTSD programs are 379 inpatients and 3,600 outpatients. A review of the Patient Treatment File (PTF) indicated that 15,038 patients were discharged with a diagnosis of PTSD from all bed sections nationwide in 1987 and 18,991 in 1988. Our current database does not provide information on numbers of outpatients treated by diagnostic category. We, therefore, cannot accurately predict the number of patients who will receive inpatient and outpatient services for PTSD in the next fiscal year.

Question: 2. The Honorable Lane Evans states that the National Vietnam Veterans Readjustment study has reported nearly one-half million Vietnam theatre veterans currently have PTSD. What outreach is being made to these veterans by the VA and how many of these veterans have been contacted by the VA?

Answer: Outreach, to provide information and assistance regarding benefits programs and VA services, has been a longstanding feature of the Department of Veterans Benefits' Veterans Services Program.

This outreach has taken many forms through recent years. Points of concentration have always included the active military pending separation or retirement and the recently separated veteran. In this regard, we have, along with the Department of Medicine and Surgery, had special concerns for the readjustment problems of newer veterans.

Through the years, we have made personal contact with new veterans through our VADS (VA Discharge System) which assures each person receives information regarding benefits and health care. This VADS outreach includes follow-up contact and places special emphasis on contact with the educationally disadvantaged.

While outreach, both personal and administrative (pamphlets, fact sheets, newsletters, etc..), has been directed toward veterans in general, it has also concentrated on certain special groups including younger veterans, minority veterans, women veterans, former POW's, older veterans and their families, the homeless, Native Americans, incarcerated veterans and others. We have placed current emphasis on three groupings considered most at risk or most in need from an information and service standpoint: homeless veterans, active military pending separation or recently separated veterans, and older veterans and their dependents/survivors.

Many of our outreach initiatives and ventures have been designed and implemented in cooperation with the Department of Medicine and Surgery or with other agencies (e.g. military service departments, Small Business Administration, Social Security Administration, Department of Labor, etc..). Currently, our Veterans Services Program is actively involved with the Readjustment Counseling Program (Vet Centers) to improve our interface, promote joint activities and presentations, and insure cooperative services to veterans, particularly those with emotional and ongoing adjustment difficulties. This strengthened effort includes meetings and training sessions for the exchange of information on our programs and on the veterans' needs.

In that regard, for example, we are aware of the Readjustment Counseling Service study which suggests 17.6% of homeless veterans demonstrate symptoms or have a diagnosis of PTSD. It has also been noted that 9.3% of the Homeless Chronically Mentally Ill program intake show symptoms of PTSD. These findings underscore the need for our outreach programs by Veterans Benefits Counselors to take the PTSD potential into consideration as we seek to provide sensitive counseling and claims assistance.

Veterans Services Divisions regularly train on topics of importance including PTSD and the human relations aspects of working with veterans and their families when such difficulties are evident or possible. Training also includes presentations by medical providers and others who assess symptoms and profiles of persons who suffer from, or allege, post traumatic stress. We recently distributed the Joint Services Environmental Support Groups publication known as the "Guide for Preparation and Submission of PTSD Research Requests" as an additional informational tool to assist our personnel. The PTSD issue has also been included in training information and guidance to foreign service posts to assure that veterans traveling or residing overseas are adequately cared for in that regard. Outreach initiatives and claims assistance into Canada have been a particularly important area for us in recent years. Many veterans, expressing difficulties with PTSD, have been aided with claims assistance and medical attention through our staff, the Canadian Department of Veterans Affairs or Canadian service organizations (including the Vietnam Veterans Coalition).

Public speaking opportunities, media contacts, etc.. regularly discuss PTSD and the claims development and health care aspects of that condition. Our various public contact and public service initiatives are designed to provide as much service to as many people as possible and, to take into account, the special needs of readjustment. We recognize there are still large numbers of people who suffer emotional trauma from experiences of the past.

The National Vietnam Veterans Readjustment Study has indicated that 20 percent of Vietnam male theatre veterans with PTSD (approximately 100,000) have sought treatment from the VA.

Question: 3. Nearly one-half million Vietnam theatre veterans are reported to currently have PTSD, but only approximately 25,000 claims for PTSD service-connection have been approved by the VA. Should more veterans be service-connected for PTSD?

Answer: All veterans have the opportunity to apply for service-connected benefits for any disabilities they believe relate to service. In addition to the approximately 25,000 veterans currently receiving compensation for PTSD, our statistics indicate that current PTSD claims are being granted at a rate of 55 percent and that the majority of cases that are disallowed are denied because PTSD is not diagnosed by the examining physician. Our reviews of PTSD claims have not led us to conclude that there is any pattern of erroneous disallowances. Therefore, we have no reason to believe that greater numbers of veterans who filed claims for service-connected benefits for PTSD should have received favorable decisions.

Question: 4. According to the proposed budget, a number of facility activations will be delayed from fiscal year 1990 to fiscal year 1991. Why is the activation of needed facilities being delayed? How will facilities be selected for delayed activation?

Answer: A policy decision was made during the 1990 budget process that projects that might be ready for activation at the end of the year would be postponed until the next year.

Regional Directors will consider programmatic MEDIPP actions, veteran eligibility requirements, budgetary constraints, actual construction slippages, and other delays in establishing priorities for projects to be activated in FY 1990.

Question: 5. According to the DVB ADP modernization schedule previously submitted to the Committee, during Fiscal Year 1990 DVB will:

a) analyze and implement short term projects;

b) identify and evaluate technical alternatives;

c) develop acquisition strategy for selected alternatives; and

d) conduct competitive solicitations.

How much support is provided in the budget for each of these activities? If any of these activities are not supported by the proposed budget, how much is needed to provide adequate support next fiscal year for those activities.

Answer: The Fiscal Year 1990 budget provides $6.9 million for analysis and implementation of short term projects, $1 million for identification and evaluation of technical alternatives, and $500,000 for development of an acquisition strategy for selected alternatives. No funding is provided in 1990 to conduct competitive solicitations.

Funding for the analysis and implementation of short term projects is adequate to complete implementation of all projects which have been approved to date. Likewise $1 million fully provides for the identification and evaluation of technical alternatives. The $500,000 provided to develop an acquisition strategy for selected alternatives will enable us to begin development of an implementation plan for the acquisitions. With this level of funding, we hope to begin conducting competitive solicitations in 1991 and begin making awards for hardware and software in 1992.

This funding supports the planning efforts to date and lays the groundwork for presenting solicitation and procurement plans as part of future budget requests.

Question: 6. The budget proposes savings of 730 FTEE and $6.2 million from contracting out. Please identify the savings associated with each type of service to be privatized. Were these savings established independently by the VA or were these savings originally established by OMB and adopted by the VA as recommended by OMB?

Answer: The FY 90 estimate of savings related to A-76 studies is based on the attached detailed listing of studies published in the Federal Register on October 5, 1988, scheduled to be conducted in FY 1989. FTEE savings were assumed to be realized at a rate equal to the Department's actual experience in FY 1987 and 1988. Dollar savings reflect one-third of the Department's actual experience, allowing the VA to retain two-thirds as an incentive.

VHS&RA did not have a substantial basis for estimating savings and accepted the cost savings generated by OMB. The limited information currently available does not support so large a savings figure.

Question: 7. How is the quality of care being delivered by the VA measured or defined? Is the quality of VA medical care improving, lessening or remaining about the same? What improvements can be made in the quality of care delivered by the VA?

Answer: Historically, quality at a VA medical center has been determined from the levels of compliance with external accrediting organizations (i.e. the Joint Commission for Accreditation of Healthcare Organizations, College of American Pathologists, American Association of Blood Banks, American College of Surgeons for Tumor Registry, etc.). This was combined with the Veterans Administration's own quality initiatives in the form of the Systematic External Review Program (SERP), which utilizes predetermined standards to measure the quality of a service's performance and the facility specific Systematic Internal Review Program which addresses at a local level the quality and appropriateness of care. In 1987, the Medical District Initiated Peer Review Organization (MEDIPRO) was implemented throughout the system as the peer review component of the quality assurance program. At the national level utilizing expert clinicians from the field, a variety of service specific quality of care indicators are being explored. Nationwide mortality and surgical morbidity and mortality studies are used as indicators (flags for further review) to assess areas for potential improvement.

There is no evidence to indicate that the quality of care at VA medical facilities is lessening. Efforts are being made to define and measure quality of care in more sophisticated ways. It is the goal of the VA to continuously improve our care to the veterans.

Enhancing quality assurance activities is the most viable means of continuously improving quality of care. This is being accomplished by developing credible clinical indicators, with the implementation of occurrence screening, the revision of the patient incident reporting system, and a better conceptualization of risk management, among others. Improved data collection and computerized monitoring and analysis assists this process.

application, the Tennessee Valley Authority (TVA) also withdrew its TS change 68 which it had submitted in its letter dated May 10, 1988.

Date of issuance: September 21, 1988

Effective date: September 21, 1988

Amendment Nos.: 83, 74

Facility Operating Licenses Nos. DPR-77 and DPR-79. Amendments revised the Technical Specifications.

Date of initial notice in **Federal Register:** November 4, 1987 (52 FR 42370. The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 21, 1988.

No significant hazards consideration comments received: No

Local Public Document Room location: Chattanooga-Hamilton County Library, 1001 Broad Street, Chattanooga, Tennessee 37402.

Tennessee Valley Authority, Docket Nos. 50-327 and 50-328, Sequoyah Nuclear Plant, Units 1 and 2, Hamilton County, Tennessee

Date of application for amendments: February 27, 1987 (TS 82)

Brief description of amendments: These amendments revise Specification 3/4.4.1.2, Reactor Coolant System, Hot Standby, in the Sequoyah Units 1 and 2 Technical Specifications (TS). The changes are to increase the number of reactor coolant system loops required to be in operation during Mode 3, Hot Standby, to two loops. The TS limiting condition for operation, action statement and surveillance requirement are being revised. The Buses for the Specification 3/4.4.1.2 are also being changed.

Date of issuance: September 22, 1988

Effective date: September 22, 1988

Amendment Nos.: 84, 75

Facility Operating Licenses Nos. DPR-77 and DPR-79. Amendments revised the Technical Specifications.

Date of initial notice in **Federal Register:** August 12, 1987 (52 FR 29928). The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 22, 1988.

No significant hazards consideration comments received: No

Local Public Document Room location: Chattanooga-Hamilton County Library, 1001 Broad Street, Chattanooga, Tennessee 37402.

Tennessee Valley Authority, Docket Nos. 50-327 and 50-328, Sequoyah Nuclear Plant, Units 1 and 2, Hamilton County, Tennessee

Date of application for amendments: May 22, 1987 (TS 87-18)

Brief description of amendments: These amendments revise the reactor trip limits for reactor coolant pump undervoltage in Table 2.2-1, Reactor Trip System Instrumentation Trip Setpoints, of the Sequoyah Units 1 and 2, Technical Specifications (TS). The minimum reactor trip setpoint is being increased for each bus from 4830 volts to 5022 volts. The minimum allowable values is being decreased for each bus from 4761 volts to 4739 volts.

Date of issuance: September 22, 1988

Effective date: September 22, 1988

Amendment Nos.: 85, 76

Facility Operating Licenses Nos. DPR-77 and DPR-79. Amendments revised the Technical Specifications.

Date of initial notice in **Federal Register:** August 12, 1987 (52 FR 29933). The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 22, 1988.

No significant hazards consideration comments received: No

Local Public Document Room location: Chattanooga-Hamilton County Library, 1001 Broad Street, Chattanooga, Tennessee 37402.

Toledo Edison Company and The Cleveland Electric Illuminating Company, Docket No. 50-346, Davis-Besse Nuclear Power Station, Unit No. 1, Ottawa County, Ohio

Date of application for amendment: December 8, 1987

Brief description of amendment: The amendment revised TS 4.6.1.2.c.3 to be consistent with the requirements of Appendix J to 10 CFR Part 50 and ANSI N45.4-1972 Appendix C.

Date of issuance: September 19, 1988

Effective date: September 19, 1988

Amendment No. 120

Facility Operating License No. NPF-3. Amendment revised the Technical Specifications.

Date of initial notice in **Federal Register:** April 6, 1988 (53 FR 11376). The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 19, 1988.

No significant hazards consideration comments received: No

Local Public Document Room location: University of Toledo Library, Documents Department, 2801 Bancroft Avenue, Toledo, Ohio 43606.

Vermont Yankee Nuclear Power Corporation, Docket No. 50-271, Vermont Yankee Nuclear Power Station, Vernon, Vermont

Date of application for amendment: May 23, 1988, as supplemented on August 15, 1988.

Brief description of amendment: The amendment revises the Technical Specifications to permit the use of the fuel type designated as GE 8X8EB.

Date of issuance: September 9, 1988

Effective date: 30 days from date of issuance

Amendment No.: 108

Facility Operating License No. DPR-28: Amendment revised the Technical Specifications.

Date of initial notice in **Federal Register:** June 15, 1988 (53 FR 22406). The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 9, 1988.

No significant hazards consideration comments received: No.

Local Public Document Room Location: Brooks Memorial Library, 224 Main Street, Brattleboro, Vermont 05301.

Wisconsin Public Service Corporation, Docket No. 50-305, Kewaunee Nuclear Power Plant, Kewaunee County, Wisconsin

Date of application for amendment: October 26, 1987, supplemented June 16, 1988

Brief description of amendment: The amendment revised the Technical Specifications (TS) to clarify existing specifications and increase the consistency within the TS.

Date of issuance: September 20, 1988

Effective date: September 20, 1988

Amendment No.: 80

Facility Operating License No. NPF-30. Amendment revised the Technical Specifications.

Date of initial notice in **Federal Register:** July 13, 1988 (53 FR 26536). The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated September 20, 1988.

No significant hazards consideration comments received: No.

Local Public Document Room location: University of Wisconsin Library Learning Center, 2420 Nicolet Drive, Green Bay, Wisconsin 54301.

Dated at Rockville, Maryland, this 27th day of September, 1988.

For the Nuclear Regulatory Commission

Steven A. Varga,

Director, Division of Reactor Projects–I/II, Office of Nuclear Reactor Regulation

[FR Doc. 88-22808 Filed 10-4-88; 8:45 am]

BILLING CODE 7590-01-M

OFFICE OF MANAGEMENT AND BUDGET

[Circular A-76]

Cost Comparison Studies Schedules

AGENCY: Office of Management and Budget.

ACTION: Publication of schedules for OMB Circular No. A-76 cost comparison studies.

SUMMARY: This Notice contains the schedules of cost comparisons that will be completed in 1989 for the Department of Transportation, Department of Treasury, Veterans Administration, General Services Administration, and the Department of Commerce. Executive Order 12615, Performance of Commercial Activities, dated November 19, 1987, requires OMB to publish the schedules as they become available. This is the initial submission; additions to these schedules, where the goals required by the Executive Order have not been met, and schedules from other agencies will be forthcoming.

The agency goals and number of positions scheduled for study are listed below:

Agency	Goal	Scheduled
Commerce	1,088 FTES	0,589 FTES.
GSA	0,805 FTES	0,838 FTES.
DOT	1,967 FTES	1,545 FTES.
Treasury	4,601 FTES	0,357 FTES.
VA	1,986 FTES	2,498 FTES.

General questions relating to the cost comparisons should be referred to the following individuals:

Commerce, John O'Brien, (202) 377–4115
GSA, John Sindelar, (202) 535–7735
DOT, Michael Siviy, (202) 366–5132
Treasury, Allen Zucker, (202) 566–6636
VA, Brodie Covington, (202) 233–4424

Specific questions relating to the VA studies shall be referred to the Directors of the Hospitals indicated.

Office of Federal Procurement Policy, Linda Mesaros, (202) 395–3300.

James C. Miller III,
Director.

DEPARTMENT OF COMMERCE

(List of Cost Comparisons That Will Be completed in 1989)

Units	Commercial activity	Location	FTES
BEA	Computer Operations	Wash DC	9
EDA	Loan Application	Wash DC/Field	59
EDA	Review and Process Computer Operations	Wash DC	9
EDA	Computer Support	Wash DC	10
NOAA	O'Hare Airport Obs	Chicago, IL	6
NOAA	National Climatic Data Center	Asheville, NC	60
NOAA	Facilities and Maintenance	Seattle, WA	13
NOAA	Marine Chart Branch	Rockville, MD	36
NOAA	Chart Reproduction	Rockville, MD	66
NOAA	NWS Engineering Activ	Wash DC/Field	64
NOAA	NMC Computer Controller	Suitland, MD	22
NOAA	NMC Computer Operat Section	Suitland, MD	28
NOAA	NWS Integrated Syst Laboratory	Silver Spring, MD	37
NOAA	NWS Training Center	Kansas City, MO	42
NOAA	NE Facilities Maintenance	Woods Hole, MA/Field	21
NOAA	NMFS Fin. Serv.	Wash DC/Field	51
NOAA	Hydrographic Field Parties	Wash DC/Field	27
OS	Operations and Maintenance	Wash DC	29
Total			589

Affected Units:
BEA—Bureau of Economic Analysis.
EDA—Economic Development Administration.
NOAA—National Oceanic and Atmospheric Administration.
OS—Office of the Secretary.

GENERAL SERVICES ADMINISTRATION

[List of Cost Comparisons That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
FSS	Artwork, Graphics	Wash, DC	23
IRMS	Federal Information Centers	Wash, DC	102
PBS	Maintenance	Pittsburgh	31
PBS	Maintenance	Belle Meade	15
PBS	Maintenance	Atlanta	31
PBS	Maintenance	Atlanta/Duluth	11
PBS	Maintenance	Charleston	7
PBS	Maintenance	Saginaw	4
PBS	Maintenance	Spokane	5
PBS	Maintenance	Wash, DC	93
PBS	Maintenance	Harrisburg	6
FSS	Ticket Audit	Wash, DC	26
FSS	Receipt, Records	Wash, DC	9
IRMS	ISOD Operations	Wash, DC	202
IRMS	Computing Resources	Wash, DC	7
PBS	Maintenance	Brooklyn	18
PBS	Maintenance	Camden/Trenton	6
PBS	Maintenance	New York City	8
PBS	Maintenance	Austin	14
PBS	Maintenance	Houston	4
PBS	Maintenance	San Antonio	8
PBS	Maintenance	Little Rock	7
PBS	Maintenance	New Orleans	9
PBS	Maintenance	Fort Worth	31
PBS	Maintenance	El Paso	6

GENERAL SERVICES ADMINISTRATION—Continued

[List of Cost Comparisons That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
FSS	Nat'l Fleet Mgmt Div	Denver	11
PBS	Maintenance	Tucson	9
PBS	Maintenance	Laguna Niguel	15
PBS	Maintenance	Alameda	5
PBS	Maintenance	San Ysidro	5
PBS	Maintenance	Los Angeles	6
PBS	Maintenance	Wash, DC	16
PBS	Maintenance	Wash, DC	34
PBS	Maintenance	Wash, DC	5
IRMS	Telephone Service	Wash, DC	20
IRMS	COMSEC	Wash, DC	30
Total			836

Affected Units: FSS—Federal Supply Service; IRMS—Information Resources Management Service; PBS—Public Buildings Service

DEPARTMENT OF TRANSPORTATION

[List of Cost Comparisons That Will Be Completed in 1989]

Units	Commercial Activity	Location	CIV FTE	MIL FTE
FAA	Payroll operations	Regions	126	0
FAA	Aircraft Maint	Field	307	0
FAA	Med Serv	HQ, Regions	10	0
MRD	Ship Preserv/Maint	3 Locations	244	0
SLS	Facility Maint	Massena, NY	34	0
USCG	Industrial	Woods Hole, MA	18	4
USCG	Facility Maint	Baltimore, MD	23	0
USCG	Security	Petaluma, CA	0	10
USCG	Security	Alameda, CA	0	9
USCG	Facility Maint	Alameda, CA	1	9
USCG	Facility Maint	Seattle, WA	9	8
USCG	Facility Maint	Mobile, AL	12	27
USCG	Industrial	New Orleans,	16	38
USCG	Industrial	Boston, MA	49	20
USCG	Facility Maint	Petaluma, CA	17	10
USCG	Ind/Fac Maint	Alameda, CA	8	78
USCG	Facility Maint	Clearwater, FL	1	15
USCG	Facility Maint	Chestin, SC	11	0
USCG	Facility Maint	New London, CT	43	55
USCG	Facility Maint	Borinquen, PR	15	4
USCG	Industrial	San Pedro, CA	11	20
USCG	Industrial	New York, NY	61	26
USCG	Facility Maint	Cape May, NJ	0	3
USCG	Industrial	Portsmouth, VA	68	26
USCG	Warehousing	Brooklyn, NY	35	25
USCG	Warehousing	Detroit, MI	2	2
USCG	Ship/Rec	Cape May, NJ	1	2
Total				1,845

Affected Units: Federal Aviation Administration; MRD—Maritime Administration; SLS—Saint Lawrence Seaway Development Corporation; USCG—United States Coast Guard.

DEPARTMENT OF THE TREASURY

[List of Cost Comparisons That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
BEP	Custodial Svcs	Washington	30
MINT	Custodial Svcs	San Francisco	15
MINT	Health Svcs	Philadelphia	7
MINT	Guard Svcs	San Francisco	229
IRS	ADP Svcs	Washington	15
IRS	Mail, Files	Washington	9
IRS	ADP Svcs	Cincinnati	5
IRS	Mail Room	Washington	21
IRS	Docket Room	Washington	26
Total			357

Affected Units: BEP—Bureau of Engraving and Printing; MINT—United States Mint; IRS—Internal Revenue Service.

VETERANS ADMINISTRATION

[Initial List of Cost Comparison That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
VAMC	Canteen Food Service	Brockton, MA	11
VAMC	Canteen Food Service	Buffalo, NY	21
VAMC	Canteen Food Service	Charleston, SC	10
VAMC	Canteen Food Service	Cincinnati, OH	12
VAMC	Canteen Food Service	Coatesville, PA	10
VAMC	Canteen Food Service	Columbia, MO	17
VAMC	Canteen Food Service	Columbia, SC	11
VAMC	Canteen Food Service	Miami, FL	25
VAMC	Canteen Food Service	Allen Park, MI	17
VAMC	Canteen Food Service	Des Monies, IA	12
VAMC	Canteen Food Service	Togus, ME	10
VAMC	Canteen Food Service	Ann Abror, MI	10
VAMC	Canteen Food Service	Atlanta, GA	19
VAMC	Canteen Food Service	Augusta, GA	13
VAMC	Canteen Food Service	Bedford, MA	12
VAMC	Canteen Food Service	Birmingham, AL	13
VAMC	Canteen Food Service	Biloxi, MS	18
VAMC	Canteen Food Service	Dayton, OH	15
VAMC	Canteen Food Service	Boston, MA	18
VAMC	Canteen Food Service	East Orange, NJ	19
VAMC	Canteen Food Service	Fresno, CA	11
VAMC	Canteen Food Service	Hines, IL	30
VAMC	Canteen Food Service	Houston, TX	24
VAMC	Canteen Food Service	Indianapolis, IN	16
VAMC	Canteen Food Service	Iowa City, IA	15
VAMC	Canteen Food Service	Jackson, MS	16
VAMC	Canteen Food Service	Kansas City, MO	13
VAMC	Canteen Food Service	Lexington, KY	16
VAMC	Canteen Food Service	Lyons, NJ	14
VAMC	Canteen Food Service	Loma Linda, CA	21
VAMC	Canteen Food Service	Memphis, TN	23
VAMC	Canteen Food Service	Johnston, City, TN	14
VAMC	Canteen Food Service	Nashville, TN	13
VAMC	Canteen Food Service	New Orleans, LA	14
VAMC	Canteen Food Service	Northport, NY	13
VAMC	Canteen Food Service	Oklahoma City, OK	13
VAMC	Canteen Food Service	Omaha, NE	12
VAMC	Canteen Food Service	Asheville, NC	14
VAMC	Canteen Food Service	Phoenix, AZ	14
VAMC	Canteen Food Service	Providence, RI	11
VAMC	Canteen Food Service	St. Louis, MO	21
VAMC	Canteen Food Service	Salem, VA	11
VAMC	Canteen Food Service	Tampa, FL	18
VAMC	Canteen Food Service	Temple, TX	15
VAMC	Canteen Food Service	Topeka, KS	12
VAMC	Canteen Food Service	Tucson, AZ	11
VAMC	Canteen Food Service	Washington, DC	19
VAMC	Canteen Food Service	Wilkes-Barre, PA	10
VAMC	Canteen Food Service	Milwaukee, WI	27
VAMC	Canteen Food Service	Gainesville, FL	20
VAMC	Canteen Food Service	Pitts. (UD), PA	25
VAMC	Canteen Food Service	Pitts. (HD), PA	10
VAMC	Canteen Food Service	Fayetteville, NC	5
VAMC	Canteen Food Service	Leavenworth, KS	9
VAMC	Canteen Food Service	West L. A., CA	46
VAMC	Canteen Food Service	Cleveland, OH	8
VAMC	Warehouse Service	Brockton, MA	14
VAMC	Warehouse Service	Cleveland, OH	19
VAMC	Warehouse Service	Columbia, SC	11
VAMC	Warehouse Service	Dayton, OH	13
VAMC	Warehouse Service	Allen Park, MI	12
VAMC	Warehouse Service	Battle Creek, MI	10
VAMC	Warehouse Service	Biloxi, MS	10
VAMC	Warehouse Service	San Juan, PR	43
VAMC	Warehouse Service	Lexington, KY	11
VAMC	Warehouse Service	Memphis, TN	12
VAMC	Warehouse Service	Mountain Home, TN	10
VAMC	Warehouse Service	Murfreesboro, TN	13
VAMC	Warehouse Service	Northport, NY	16
VAMC	Warehouse Service	St. Louis, MO	12
VAMC	Warehouse Service	San Diego, CA	10
VAMC	Warehouse Service	San Antonio, CA	12
VAMC	Warehouse Service	Tampa, FL	12
VAMC	Warehouse Service	Tuskegee, AL	10
VAMC	Warehouse Service	West Haven, CT	11
VAMC	Warehouse Service	Sepulveda, CA	11
VAMC	Warehouse Service	North Chicago, IL	13
VAMC	Warehouse Service	Temple, TX	8

VETERANS ADMINISTRATION—Continued

[Initial List of Cost Comparison That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
VAMC	Warehouse Service	News York, NY	17
VAMC	Warehouse Service	Boston, MA	9
VAMC	Warehouse Service	Miami, FL	21
VAMC	Switchboard Warehouse Service	Long Beach, CA	13
VAMC	Switchboard Service	Memphis, TN	12
VAMC	Switchboard Service	Minneapolis, MN	11
VAMC	Switchboard Service	San Francisco, CA	10
VAMC	Switchboard Service	Washington, DC	10
VAMC	Switchboard Service	Milwaukee, WI	11
VAMC	Transcription Service	Denver, CO	10
VAMC	Transcription Service	Cleveland, OH	18
VAMC	Transcription Service	Hines, IL	12
VAMC	Transcription Service	Minneapolis, MN	21
VAMC	Transcription Service	New Orleans, LA	10
VAMC	Transcription Service	Palo Alto, CA	10
VAMC	Transcription Service	Sah Antonio, TX	11
VAMC	Transcription Service	Tuskegee, AL	10
VAMC	Transcription Service	Milwaukee, WI	17
VAMC	Laundry Service	Brockton, MA	37
VAMC	Laundry Service	Buffalo, NY	27
VAMC	Laundry Service	Chillicothe, OH	18
VAMC	Laundry Service	Miami, FL	15
VAMC	Laundry Service	Lake City, FL	27
VAMC	Laundry Service	Lebanon, PA	18
VAMC	Laundry Service	Lyons, NU	37
VAMC	Laundry Service	Madison, WI	11
VAMC	Laundry Service	Martinsburg, WV	28
VAMC	Laundry Service	Murfreesboro, TN	24
VAMC	Laundry Service	Northampton, MA	14
VAMC	Laundry Service	Omaha, NE	16
VAMC	Laundry Service	San Diego, CA	14
VAMC	Laundry Service	San Antonio, TX	18
VAMC	Laundry Service	Tuscaloosa, AL	20
VAMC	Laundry Service	Tuskegee, Al	38
VAMC	Laundry Service	Waco, TX	34
VAMC	Laundry Service	Bath, NY	11
VAMC	Laundry Service	Bay Pines, FL	38
VAMC	Laundry Service	Battle Creek, MI	51
VAMC	Laundry Service	Sioux Falls, SD	10
VAMC	Laundry Service	Alexandria, LA	24
VAMC	Laundry Service	Kerrville, TX	9
VAMC	Laundry Service	North Chicago, IL	37
VAMC	Laundry Service	Denver, CO	16
VAMC	Laundry Service	San Juna, PR	17
VAMC	Laundry Service	Fargo, ND	8
VAMC	Laundry Service	Albuquerque, NM	13
VAMC	Grounds Maintenance	Brooklyn, NY	14
VAMC	Grounds Maintenance	Cleveland, OH	11
VAMC	Grounds Maintenance	Dayton, OH	15
VAMC	Grounds Maintenance	Lebanon, PA	10
VAMC	Grounds Maintenance	Waco, TX	12
VAMC	Grounds Maintenance	Milwaukee, WI	12
VAMC	Grounds Maintenance	Canandaigua, NY	11
VAMC	Chauffeur Service	Brockton, MA	10
VAMC	Chauffeur Service	Cleveland, OH	13
VAMC	Chauffeur Service	Dayton, OH	16
VAMC	Chauffeur Service	Bath, NY	10
VAMC	Chauffeur Service	St. Louis, MO	14
VAMC	Chauffeur Service	North Chicago, IL	19
VAMC	Fire Protection	Ft. Lyon, CO	13
VAMC	Fire Protection	Butler, PA	15
VAMC	Fire Protection	Hampton, VA	11
VAMC	Fire Protection	Tomah, WI	14
VAMC	Fire Protection	Livermore, CA	12
VAMC	Fire Protection	Tacoma, WA	11
VAMC	Fire Protection	Alexandria, LA	11
VAMC	Fire Protection	Castle Point, NY	16
VAMC	Fire Protection	Montrose, NY	15
VAMC	Fire Protection	Tuskegee, AL	16
VAMC	Fire Protection	Northport, NY	15
VAMC	Fire Protection	Martinsburg, WV	15
VAMC	Fire Protection	Murfreesboro, TN	17
VAMC	Fire Protection	Battle Creek, MI	18
VAMC	Fire Protection	Hines, IL	15
VAMC	Fire Protection	Little Rock, AR	11
VAMC	Fire Protection	Canandaigua, NY	11
VAMC	Fire Protection	Northampton, MA	12
VAMC	Fire Protection	Lyons, NJ	18

VETERANS ADMINISTRATION—Continued

[Initial List of Cost Comparison That Will Be Completed in 1989]

Units	Commercial activity	Location	FTE
VAMC	Fire Protection	Cleveland, OH	10
VAMC	Fire Protection	White City, OR	11
Total			2,498

Affected Units: VAMC—Veterans Administration Medical Centers.

[FR Doc. 88-22948 Filed 10-4-88; 8:45 am]

BILLING CODE 3119-01-M

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

United States-Canada Free-Trade Agreement; Applications and Nominations of Individuals To Serve on Binational Dispute Settlement Panels for Review of Antidumping and Countervailing Duty Determinations

AGENCY: Office of the United States Trade Representative.

ACTION: Invitation for applications from, and nominations of, candidates to serve on binational panels convened to review antidumping and countervailing duty matters under Chapter 19 of the United States-Canada Free-Trade Agreement.

SUMMARY: Chapter 19 of the United States-Canada Free-Trade Agreement (FTA) provides for the establishment of a roster of individuals unaffiliated with either the U.S. or Canadian Governments who are willing to serve on binational panels convened to review: (1) Final determinations in U.S. or Canadian antidumping or countervailing duty cases involving imports from the other country; and (2) amendments to either country's countervailing duty or antidumping laws. This notice invites applications from, and nominations of, U.S. citizens wishing to be considered for inclusion on the roster of candidates eligible to be selected to serve on such panels and summarizes eligibility criteria for roster members and panelists. Nominations must be received by October 15, 1988. Applications must be received by October 31, 1988.

FOR FURTHER INFORMATION CONTACT: Pamela Cassidy, Legal Assistant, Office of the General Counsel, at (202) 395-3432.

Background

President Reagan and Prime Minister Mulroney signed the FTA on January 2, 1988. The United States-Canada Free-Trade Agreement Implementation Act (the Act), which approved the FTA and provided U.S. implementing authority, was signed into law on September 28, 1988. Provided that both the United States and Canada take necessary implementing steps, the FTA will enter into force on January 1, 1989.

Chapter 19 of the FTA creates a procedure for the review by binational panels of final determinations in U.S. and Canadian antidumping and countervailing duty (AD/CVD) proceedings involving imports from the other country. Each panel will be composed of five non-governmental experts. The Chapter also provides for panels to review amendments to U.S. and Canadian AD/CVD law. Under Chapter 19, the United States and Canada must develop a roster of U.S. and Canadian citizens qualified to be selected as panelists in individual cases. Chapter 19 sets out certain eligibility criteria for roster members, designed to assure the competence and objectivity of panelists. Section 405 of the Act provides further requirements and procedures for the selection of U.S. individuals to be roster members or panelists, and the Statement of Administrative Action approved by the Act provides additional guidance on U.S. implementation. Individuals interested in being included on the roster and serving as panelists should carefully consult the provisions of Chapter 19 of the FTA, Title IV of the Act, and relevant portions of the Statement of Administrative Action, and should not rely exclusively upon the general summary included in this notice.

Functions of Panels

As noted above, Chapter 19 provides for the use of binational panels both to review AD/CVD determinations involving imports from the other country and to consider amendments to U.S. or Canadian AD/CVD law.

(1) Review of AD/CVD Determinations

Under Chapter 19, Canada and the United States retain the right to impose countervailing or antidumping duties in accordance with their national laws, including against products of the other country. Final administrative determinations under those laws will be subject to review by binational panels, rather than by national courts, if requested by an appropriate U.S. or Canadian party to the proceeding, to the extent that such determinations involve products of the other country. Binational panels will review such determinations to decide whether the administering authority complied with the relevant national law, using the standard of review that would otherwise have been applied by a national court in such circumstances. A panel may uphold the administrative decision or remand the case to the administering authority for action not inconsistent with the panel's decision. Panel decisions are not subject to judicial review, but may be reviewed in limited circumstances by a binational "Extraordinary Challenge Committee." The United States and Canada are obligated under Chapter 19 to give effect to final panel decisions.

(2) Review of Amendments to AD/CVD Law

Chapter 19 also provides that, at the request of either the United States or Canada, a binational panel will review and issue a declaratory opinion concerning whether an amendment to the other country's AD/CVD laws made after entry into force of the FTA is inconsistent with the provisions of the General Agreement on Tariffs and Trade (GATT), the GATT Antidumping or Subsidies Codes, or the object and purposes of the FTA.

Composition of Panels

Chapter 19 provides for the development of a roster of fifty potential panelists, with each government selecting twenty-five individuals. A separate five-person panel will be formed for each review of an AD/CVD administrative determination or legislative amendment. To form a panel, the U.S. and Canadian Governments will each appoint two panelists, normally by drawing upon individuals from the roster. The two governments will then attempt to agree upon a fifth panelist. In the absence of such agreement, the fifth panelist will be selected from the roster either by agreement among the four panelists

Question: 8. What further reductions in medical care or services are being considered? How can further reductions in medical care and services be avoided?

Answer: Basically, VA medical facilities have reallocated resources from care for B and C categories of veterans to other areas. In addition, some programs (such as substance abuse programs) have been closed to preserve funds. Approval of the request for a supplemental appropriation will help reduce the need for such reallocations.

Question: 9. In Fiscal Year 1990, the VA will pay an estimated $54.6 million to rent VA Regional Office space. Even though some space rented for VA regional office use is inadequate and unsafe, the proposed budget fails to propose even one colocation. Why is there a preference for continuing to pay massive amounts of rent for second class space for VA regional offices? Has the quality of rental space used for VA Regional Offices been assessed? What are the results of the assessment?

Answer: The VA does not prefer to continue to pay massive amounts of rent for space that is in less than first class condition. Admittedly, not all facilities rented by the VA for regional offices are in good repair and completely satisfactory to our standards for sound operating environments. Generally, the principal areas of concern involve inadequate heating, ventilation and air conditioning. Most DVB facilities are leased from GSA. As such, it is GSA's responsibility to assure the condition of the physical plant. It is our understanding that GSA periodically performs an evaluation, similar to the Department's Capital Facilities Study, for the buildings it owns.

VA regional office space is constantly monitored to maintain the highest standards possible. Where deficiencies are found, we use every means available in working with the General Services Administration to rectify and improve out-of-line conditions. Attached for your information is a letter dated June 10, 1988, to GSA detailing deficiencies at four DVB leased facilities.

In terms of selecting projects for colocation, DVB considers a number of factors including operational efficiencies, site/building availability at VA medical centers, the working environment and physical plant of the existing regional office space, and what is the most cost-effective means of providing regional office space.

Question: 10. About $2.4 billion in outstanding debt is owed to the VA. Of this amount, how much will the VA or its agents be able to collect? What actions are being taken to reduce the amount of new debt owed to the VA?

Answer: During fiscal year 1988, the VA collected $324 million on delinquent debts resulting from benefit overpayments or loan guaranty foreclosures. We anticipate collecting at least that amount or more through the continued use of collection tools such as IRS Refund Offset, Federal Salary Offset, Referral to Credit Reporting Agencies and Referral to Private Collection Agencies. We are also in the process of procuring an automated telephone dialing system which will allow us to contact debtors by telephone on an automated basis. This should greatly enhance our collection efforts. In terms of debt prevention, the following actions have been taken:

JUN 10 1988

Mr. John Alderson
Acting Administrator
General Services Administration
18th and F Streets, NW
Washington, DC 20405

Dear Mr. Alderson:

Over the past years, the VA (Veterans Administration) and GSA (General Services Administration) have worked successfully in a number of cases to provide quality workplace environments for the VA to carry out its mission. The working relationships between our staffs are positive in such places as Indianapolis, Indiana; Los Angeles, California; Pittsburgh, Pennsylvania; Roanoke, Virginia; and Winston-Salem, North Carolina.

Unfavorable conditions continue to exist, despite the best staff efforts, which adversely impact operations. Because of this, your support in resolving issues in the following localities is requested:

Baltimore, Maryland
Jackson, Mississippi
San Francisco, California
St. Petersburg, Florida

A brief description of the issues at each location is enclosed. Questions may be directed to Mr. Thomas R. Wagner, Chief, Space, Procurement and Work Measurement Staff (201B), on 233-3021.

We wish to emphasize the need to correct these workplace issues to the satisfaction of both our organizations. Your cooperation and assistance are appreciated.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

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GSA/VA ISSUES

1. Baltimore, Maryland

   a. Location. G. H. Fallon Federal Building
   31 Hopkins Plaza
   GSA Building No.: MD0055ZZ

   b. Development, implementation and completion of space alteration plans have been on-going difficulties since 1984. Since April 1988, the location of child care facilities has become an issue because of the building's major tenant (IRS) proposing to GSA the displacement of VA public contact activities from their present location on the first floor without discussing it with VA officials. VA Central Office has not been officially notified by GSA of the planned implementation.

2. Jackson, Mississippi

   a. Location: Dr. A. H. McCoy Federal Building
   100 W. Capitol Street
   GSA Building No.: MS0083ZZ

   b. VA elements, located on what is known as the "B" section of the second floor, have inadequate air treatment (extreme cold in winter and heat in summer) because of the building design. After many discussions with and letters to GSA, the only acceptable solution is the relocation of the VA activities. The problem is the lack of available space to relocate within the federal building.

3. San Francisco, California

   a. Location: 211 Main Street
   GSA Building No.: CA4970ZZ

   b. Since October 1986, planning, development and implementation of a space alternation project to reduce space by 25,000 square feet has not been completed. Inaction by the building owner in addressing city code requirements has stalled the project.

   c. This regional office is to be relocated to the new Federal Building in Oakland, California in FY 1991.

4. St. Petersburg, Florida

a. Location: William Cramer Federal Building
144 First Avenue South
GSA Building No.: FL0080ZZ

b. Rodent infestation, custodial services, physical security of building, elevator maintenance and telephone installation have been points of difficulty to varying degrees since 1983. Until recently all other tenants were relocated to other sites in the Tampa/St. Petersburg area. A Military Entrance Processing Center was recently relocated to this building because the building they previously occupied was sinking into the Florida landscape. The Cramer Federal Building has been cited by the VA Inspector General's Office as being inadequate for VA operations (A copy of this report was forwarded to the GSA Inspector General).

c. This regional office is under consideration in the Agency's colocation program.

Education Service:

Debt prevention was enhanced in September 1988 with the automation of check intercept procedures. This procedure allows us to automatically retrieve checks that were issued subsequent to an award adjustment which changed the beneficiaries entitlement. In addition, the Education Service issued DVB Circular 22-88-6 which was directed toward involving school officials at institutions of higher learning in our debt prevention efforts. Legislation on mitigating circumstances was passed in October 1988 and will be implemented in May 1989. This will prevent debts by excusing a single instance of receiving nonpunitive grades. For the first quarter of fiscal years 1987, 1988 and 1989, the number of education debt accounts have been reduced from 21,816 to 16,953 to 15,511 respectively. The dollar value of the accounts has dropped correspondingly from nearly $9 million in FY 1987 to approximately $6.5 million for the first quarter of FY 1989. Debt creation in Chapter 30 has been low due to monthly verifications of pursuit and we project further reductions with the implementation of mitigating circumstance legislation.

Compensation and Pension Service:

Debt prevention was enhanced in September 1988 with the automation of check intercept procedures. This procedure allows us to automatically retrieve checks that were issued subsequent to award adjustments which changed the beneficiaries' entitlement. In addition, changes were made in Hines to delay delivery of C&P pay changes to Treasury. This was accomplished in October 1988 and we project a $10 million dollar reduction in overpayments from this initiative. By May 1989, Treasury will make additional changes that will allow for further delays in delivering pay change tapes. As a result, we project further debt reduction of $20 million.

Currently the C&P Service is considering possible legislative proposals that may further reduce debts. Also, a debt prevention assessment is planned by the C&P staff this summer. C&P debt creation in CARS was reduced by 15 percent in just the first seven months of FY 1988 as compared with the first seven months of FY 1987. However, that trend was reversed as a result of the Semenchuk decision and the centralization of death accounts in CARS. One major improvement was noted in the reduction of the average amount of debts established. Currently, compensation and pension debts average $1370 as compared to $2161 in FY 1987.

Loan Guaranty:

The continued increase in the creation of loan guaranty debt is the major debt management problem for the Department. During the past decade, the mortgage lending and real estate industries have been battered with catastrophic losses resulting from acute regional and national economic downturns. Most recently, the southwestern United States (oil belt) has suffered extensive property depreciation and extremely heavy foreclosures. In Texas alone, business and personal bankruptcies totaled 37,170 for the 12 month period ending June 30, 1987, compared to 9,589 in June 1981. As in private industry, the VA has experienced heavy foreclosures. In FY 1988, we established $575 million in new debts leaving us a total loan guaranty debt of $1.75 billion. The Department has made numerous changes to improve underwriting, enhance property management, and reduce time to foreclosure. In addition, a pilot program for servicing is underway in Houston, Texas. We believe that by enhancing servicing, foreclosures can be avoided or reduced.

Veterans Service:

The Veterans Assistance Service is considering possible legislative initiatives that may assist in our debt prevention efforts. Also, the Service places emphasis on debt prevention in their employee training program as well as in outreach efforts with Service Organizations and other interest groups.

Question: 11. The budget proposes acquisition and procurement savings of $53.6 million. Please provide the basis of these estimated cost savings.

Answer: The two major components of the total are savings of $15 million from award of a competitive contract for IV solutions and $12 million from the FASTRAC initiative. The remainder of the $53.6 million projected savings might be able to be achieved through standardization, district consolidated procurement, shared procurement, FSS-Competition/Requoting, and reductions in local procurement.

Question 12. The CHAMPVA active beneficiary inventory has been reduced from approximately 210,000 individuals to 112,000. What is the impact of this reduction on program workloads and costs? Does the budget reflect the effects of this reduction?

Answer: The impact of the centralization of CHAMPVA administrative processing on program workloads and cost are reflected in both the FY 88 and FY 89 budgets. The FY 88 budget, expected to produce a cost savings of $5.5 million, contains an estimated workload reduction of 17 ADC and 16,919 outpatient visits. The FY 89 budget reflects a similar $9 million cost savings plus 26 ADC and 26,210 outpatient visits, for a combined two year cost savings of $14.5 million. An additional $20 million in savings are being reprogrammed to support the recent supplemental request.

Question: 13. Why are 15,447 fewer inpatient admissions projected in Fiscal Year 1990?

Answer: The projected decrease in VA hospital admissions is primarily the result of a redistribution of levels of care supportable in VA Medical Centers. Workloads will be adjusted across most Medical Care appropriation activities to assure access to quality health care for veterans whose care is mandated by law.

Question: 14. Please provide vet center actual or proposed average employment for Fiscal Year 1987 through 1990.

Answer: Readjustment Counseling Service system-wide actual average employment, as indicated by the end of year cumulative FTEE, for Fiscal Year 1987 was 782. The end of year actual cumulative FTEE for Fiscal Year 1988 was 799 which reflects the initiation of 4 new 3-FTEE vet centers in Hawaii and 2 new 3-FTEE vet centers in West Virginia. The proposed average employment for Fiscal Years 1989 and 1990 is 815 FTEE.

CONGRESSMAN KENNEDY

Question: 1. Please explain the rationale for making the following reductions in the VA FY 90 budget in light of the facts presented:

a. a reduction in the number of patients treated in VA medical centers by 17,516 admissions per year when there exists evidence that service-connected veterans are already being denied patient care services and are enduring substantial delays in treatment.

b. a decrease in the number of patients treated in long-term care facilities by 14,452 admissions per year when chronically ill veterans are currently occupying acute care beds because there are no long-term care beds available and in addition to the fact that the aging veteran population will place a higher demand on long-term care services in the upcoming years.

c. a decrease of 2,400,000 outpatient visits per year when hospital administrators are shifting to outpatient care in an attempt to save inpatient dollars thus placing a higher demand on outpatient services.

d. a decrease of 8,256 full-time medical employees when the VA medical care personnel shortage is so severe that wards have been closed and patient care services cut back.

Answer: The 1990 budget requests a level of resources necessary to provide quality medical care to all veterans whose care VA is obligated by law to provide. Treatment of other veterans will be on a resource available basis.

Question: 2. How much will the VA spend on substance abuse programs this fiscal year and does this represent an increase or decrease from funding levels in the previous years?

Answer: In FY 1988, we estimate that approximately $327 million was spent on alcohol and drug dependence treatment in the VA. Due to the funding shortfall for FY 1989, VA medical centers are curtailing services to Category "B" and "C" veterans and are making other programmatic adjustments, some of which impact the capacity to provide alcohol and drug dependence treatment. As a result of these actions, we do not have an accurate estimate of the level of expenditures in FY 1989.

Question: 3. What is the projected funding level for the substance abuse programs in the proposed FY 90 budget including staffing levels, inpatient, outpatient and contract programs?

Answer: The FY 1990 budget does not break-out expenditures for alcohol and drug dependence related disabilities.

Question: 4. I understand that a number of VAMC's, primarily in the Northeastern United States, have completely suspended or severely reduced their levels of outpatient and inpatient substance abuse treatment in the recent months.

4a. What was the reason for this reduction in services--lack of demand or lack of resources?

Answer: The primary factor was to free up resources for other activities and the fact that alternative treatment options were available.

Question: 4b. Was the VA Central Office aware of these closures? If so, did you sanction these moves?

Answer: For FY 1989, advance notification to Central Office was required before closures or reductions proposed by individual field facilities were approved by the Regional Director. When this process was new, notification of Central Office was not provided on a timely basis in a number of instances. Those decisions were nevertheless reviewed, and action taken as appropriate.

Question: 4c. Is this an appropriate way to address the national crisis of substance abuse in the United States?

Answer: Patients in need of these services have been referred to other VA operated substance abuse programs or to programs within the patient's community. The VA is proud of its role in providing substance abuse programs and will continue to provide quality service.

Question: 5. How many more VA substance abuse programs are you planning to close this fiscal year? And next fiscal year?

Answer: At this time, there are no firm plans to close any more substance abuse programs.

Question: 6. P.L. 100-690 authorized $15 million each year for the next three years for the Veterans Administration to augment their substance abuse programs. If the Congress were to appropriate these funds, will you use these resources to reopen those treatment programs recently closed?

Answer: Funds specifically earmarked through legislation will be expended for the purposes specified. Whether the closed program would be reopened or new programs would be funded has not been decided.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

March 10, 1989

Honorable G.V. "Sonny" Montgomery, Chairman
House Veterans Affairs Committee
335 CAnnon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

In response to your correspondence of February 17, 1989, the attached sheet contains our answers to the questions asked by Representative Bob Stump.

Sincerely,

E. Philip Riggin, Director
National Legislative Commission

Attachment

Q. #1. What would the American Legion consider a reasonable below par percentage limitation on without recourse loan sales, as mentioned at page 20 of your statement?

A. The American Legion believes that a reasonable rate for loan sales without recourse to be no more that 10% below par. We recognize that without recourse sales will normally bring less than par value prices since, depending on the current market, the mortgage instrument may not generate sufficient income to support a par value purchase. However, it is our view that selling mortgages on a without recourse basis at less than 90% of par value is not financially sound because the income stream from the mortgage will, over time, compensate for any short term revenue realized from the sale.

Q. #2. Does the American Legion believe that the establishment of the Hearing Officer position in regional offices is a good idea?

A. Prior to its establishment, The American Legion felt replacing rating boards with Hearing Officers for the purpose of conducting personal hearings would be advantageous to most claimants and improve the due process procedure. The results of the first five months of the program were recently discussed with service officers of The American Legion. Their experience has been generally positive.

The changes made under the program are both a matter of substance and perception. Claimants feel a Hearing Officer will be more empathic rather than hostile or adversarial. They are more likely to get a full, fair, and impartial hearing, particularly since that individual has not been involved in previously denying the claim. From initial reports, Hearing Officers appear to be very much concerned with the development of the evidence in a claim. Action to obtain additional clarifying or supporting evidence or examinations is frequently undertaken. Decisions received by the claimant are felt to be more informative and understandable than either the rating board's denial notice or the Statement of the Case.

Some concern was expressed with regard to the heavy hearing schedule and backlogs at several stations. The workload for the individual Hearing Officers has been very heavy. In the shortrun this may not cause a problem, but over an extended period of time it could have an adverse affect on the "quality" of decisions. "Burnout" could become a factor. Timeliness is also a problem at certain stations, both in terms of a delay in the scheduling of a hearing and release of the Hearing Officer's decision. The latter problem can be traced to limited available administrative support at the Hearing Officer's home station. It must be pointed out that the Hearing Officer program was implemented without any budget support for additional administrative staff.

Thus far, we feel the program is fulfilling its overall objective.

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ERRATA

On cover and title page delete "Serial No. 100-2" and insert in lieu thereof "Serial No. 101-2"

FISCAL YEAR 1990 BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

FEBRUARY 7 AND FEBRUARY 9, 1989

Printed for the use of the Committee on Veterans' Affairs

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